



CERTIFICATION OF MEDICAL RECORDS

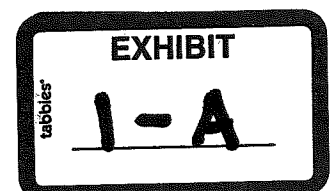
I hereby certify that the attached medical record of:

A [REDACTED] H [REDACTED]

Is a true copy of the medical record on file at the WILLIS KNIGHTON HEALTH SYSTEM, 2600 Greenwood Road, Shreveport, LA; that these records were prepared by the medical facility personnel during the course of business at or near the time of the visit; that I am the duly authorized Health Information Management Representative, and I have the authority to certify same.

11/21/19
Date

Patricia Lee, RHIT
Health Information Management Representative



Willis-Knighton South
2510 Bert Kouns Industrial Loop
Shreveport, LA 71118

Patient Name: [REDACTED]

Adm No: K20034595213
DOB: 10/01/2013
Age: 4Y F
Corp ID: 000001116206

MRN: 1116206
Location: Inpatient - S4PI-S404A
Ord No: 90028
Hospital: WKS

Ordering Dr: MINH QUACH TRI TRAN

CC: GIAO NGOC DO

Final Report

Admitting Diagnosis: RESPIRATORY FAILURE
Reason For Exam: post cardiac arrest
Procedure Date: 02/11/2018
Procedure: SCT - CT, head or brain w/o contrast

Interpretive Location: BOS
Accession Number: 3961857
CPT Code: 70450

IMPRESSION: Findings compatible with global hypoxic-ischemic encephalopathy. These findings could be corroborated with diffusion weighted MR imaging.

RESULT:

Procedure: CT, head or brain w/o contrast

Clinical Information: post cardiac arrest

Comparison: 2/10/2018

Findings:

The study again demonstrates decreased attenuation in the basal ganglia bilaterally. There is loss of normal gray-white matter differentiation. CSF containing spaces are effaced. Findings are compatible with global hypoxic-ischemic encephalopathy.

TECHNIQUE:

Exam: Axial CT of the brain without IV contrast
Type of Scan: Interrupted supine
Slice Thickness: 5 mm
Superior Extent: Vertex
Inferior Extent: Skull base
IV Contrast: No
Oral Contrast: No

All CT scans are performed using radiation dose reduction techniques. Technical factors are evaluated and adjusted to ensure appropriate moderation of exposure. Automated dose management technology is applied to adjust the radiation dose to minimize exposure while achieving a diagnostic-quality image. Dose reduction techniques were used according to ACR guidelines.

Electronically Signed by: CORNELIUS J BOS M.D. on Feb 11 2018 4:19P

Techs: Susan D Davis
Additional Staff:

Read by: CORNELIUS J BOS M.D. on Feb 11 2018 4:16P

Electronically Signed by: CORNELIUS J BOS M.D. on Feb 11 2018 4:19P

Printed: Feb 11 2018 4:20PM

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Assessment Report

Generated from 02/10/2018 00:00 to 02/18/2018 23:59

Pt Name:	██████████ L	MRN:	1116206
Pt ID:	0101757329	Acct No:	K20034595213
DOB:	10/01/2013	Age/Sex:	4Y/F
Adm DTime:	02/10/2018 09:11	Atn Dr:	Do, Giao MD
Nurs Sta:	S 4 PICU	Rm & Bed:	
Dx:			
Alrg:	codeine, Fish Containing Products, Fish containing products		

Admission Assessment

Assessment Sts	Complete	Collected DTime	02/10/2018 10:00
Collected By	Julie E Bolding, RN		
<u>Genitourinary Admit Assessment</u>			
Urinary catheter present on admission	Indwelling urinary catheter inserted at WKHS	Indwelling Urinary Catheter present on admission	Yes
Date / Time Inserted	02/10/2018 06:00	Catheter type	Indwelling urinary
Catheter size	Other (specify)	Other catheter size	12F
Equipment	Pads / briefs	External genitalia	WDL except
Female genitalia	Other (specify)	Female genitalia description	Tears at entrance to vaginal wall - look fresh. 2-3 tears noted. CPS/SPD notified by Denise, Nursing supervisor
Comment	Awaiting exam by SANE nurse.		

Musculoskeletal Assessment

Musculoskeletal	Unable to assess	Bones and Joints	Unable to assess
Reason unable to assess	Intubated, Sedated	Reason unable to assess	Intubated, Sedated

Neurological Assessment

Eye opening	Spontaneous	Motor response	No movement
Verbal response	Makes no sounds	GCS Total Score	6
Neurological	Unable to assess	Pupil size, left	Small
Pupil size, right	Small	Pupil reaction, left	Sluggish
Pupil reaction, right	Sluggish	Reaction with light	2
Reaction with light	2		

Integumentary Assessment

Integumentary	WDL except	Skin temperature	Hot
Texture	Dry	Location Site 1	Other (specify)
Location detail - Site 1	Entrance to vagina	Type of wound Site 1	Skin tear
Location Site 2	Abdomen, right	Type of wound Site 2	Scar

Braden Skin Risk Assessment

Mobility: Ability to change and control body position	Completely Immobile	Activity: Degree of physical activity	Bedfast
Sensory Perception:	Very Limited	Moisture	Rarely Moist
Friction and shear	No Apparent Problem	Nutrition: Usual food intake pattern	Adequate
Tissue perfusion and oxygenation	Adequate	Modified Braden Score	18

Fall Risk Assessment

Pt Name: ██████████ L
Rm/ Bed:

MRN: 1116206
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Assessment Report:

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Assessment Report

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Nurs Sta:	S 4 PICU	Rm & Bed:	
Dx:			
Alrg:	codeine, Fish Containing Products, Fish containing products		

CM Notes

Assessment Sts	Complete	Collected DTime	02/12/2018 13:11
Collected By	Frederica D Morris, LMSW		

CM Notes

Care Management Note

COC NOTE;
THE SW WAS INFORMED CPS AND SHREVEPORT POLICE IS INVOLVED (SEXUAL ASSAULT).
LASHUNDA PRIM 318 676-7323, 318 676-7322, CELL 318 560-1676, DETECTIVE ALLDAY 318 834-8855.

Clinical Note:

CM Pediatric Assessment

Assessment Sts	Complete	Collected DTime	02/11/2018 14:58
Collected By	Linda F Blake		

CM Pediatric Assessment

Lives with	Parent	Name of caregiver	JENNIFER ALEXANDER
Caregiver cell phone #	(318)210-3821	Does caregiver smoke?	Never smoker
Smoking cessation program information	No	Main source of income	Employed
Problems with transportation	No	Physical/Emotional history	RESPIRATORY FAILURE
Family problems/needs that affect child's condition	NONE NOTED AND/OR REPORTED	Church affiliation	CHRISTIAN
School attending	NORTH HIGHLANDS	Current grade	PRE-SCHOOL
Interventions/Notes	PATIENT IS A 4YR. OLD FEMALE WHO LIVES IN THE HOME WITH HER MOTHER. THE PATIENT HAS GOOD FAMILY SUPPORT. THE M/GRANDMOTHER AT BEDSIDE DURING SWS VISIT. THE PATIENT'S PED DOCTOR IS DR. SCOTT ALLEN OF UNNIVERSITY HEALTH. THE PATIENT IS ENROLLED IN SPEECH THERAPY AT HER SCHOOL. SS WILL CONTINUE TO FOLLOW.		

Clinical Note:

Pt Name:	██████████ L	MRN:	1116206
Rm/ Bed:			Page 1 of 1

Assessment Report

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Nurs Sta:	S 4 PICU	Rm & Bed:	
Dx:			
Alrg:	codeine, Fish Containing Products, Fish containing products		

Central Venous Access

Assessment Sts	Complete	Collected DTime	02/10/2018 10:30
Collected By	Julie E Bolding, RN		

Central Venous Access

Dressing condition, site 1	Clean, dry, intact	Date Dressing change due, site 1	02/12/2018
Dressing	Applied chlorhexidine - impregnated sponge		

Clinical Note:

Death Assessment

Assessment Sts	Complete	Collected DTime	02/16/2018 10:44
Collected By	Tiffany R Jemer, RN		

Death Assessment

Date / Time Death pronounced	02/16/2018 10:10	Pronounced by	Dr Giao Do, brain death
Preliminary Cause of Death	Cardiopulmonary arrest	Physician notified	Dr Do at bedside and pronounced patient brain dead
Next of kin notified	family at bedside and brain death discussed with them per Dr Do	Coroner case	Autopsy
Date / Time Coroner notified	02/16/2018 10:44	Coroner's representative notified	K. Wright and M. Johnson from Coroner's office on unit to see patient
Body released by coroner	No	Autopsy	Yes
Complete Authorization of Autopsy and obtain physician order	Unknown, coroner's case	University Health's representative notified	LOPA representative Marji states she will notify University Health
Funeral Home name	Benevolent	Funeral Home representative notified	LOPA representative Marji states she will notify funeral home
Date / Time of Death	02/16/2018 10:10		

LOPA Notification of Referral

Referral number	1802-0647	Date / Time of referral	02/11/2018 10:15
Screened by	MAGGIE BENEZECH	Date / Time of Death	02/16/2018 10:10
Ventilated patient	Yes	Comments	LOPA on unit to assume care of patient at 1600.
Date / Time Death pronounced	02/16/2018 10:10		

Clinical Note:

Edema Additional Findings

Pt Name:	██████████ L	MRN:	1116206
Rm/ Bed:			Page 73 of 139

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 DOB: 10/01/2013 Age/Sex: 4Y/F
 Adm DTime: 02/10/2018 09:11 Attn Dr: Do, Giao MD
 Nurs Sta: S 4 PICU Rm & Bed:
 Dx:
 Allrg: codeine, Fish Containing Products, Fish containing products

Reassessment

Assessment Sts Complete Collected DTime 02/12/2018 07:10
 Collected By Tiffany R Jemer, RN

Pain / Sedation Assessment

Activity	Lying quietly, normal position, moves easily	Cry	No cry
Consolability	Content, relaxed		

HEENT Assessment

Head	WDL	Eyes	WDL except
Conjunctiva and sclera, left	Sclera jaundice	Conjunctiva and sclera, right	Sclera jaundice
Ears	WDL	Nose	WDL
Mouth	WDL	Throat	Unable to assess
Reason Unable to Assess	Intubated, Sedated		

Respiratory Assessment

Oxygen	WDL except	FIO2 (%)	50
O2 Delivery method	Endotracheal tube	Respiratory	WDL except
Ventilated	Yes	Breath sounds within defined limits	WDL except
LUL	Coarse rales	LLL	Coarse rales
RUL	Coarse rales	RML	Coarse rales
RLL	Coarse rales		

Cardiovascular Assessment

Cardiovascular	WDL	Peripheral circulation	WDL except
Radial pulse, left	Inaccessible due to dressing in place		

Gastrointestinal Assessment

Gastrointestinal	WDL except	Abdomen	Distended, Soft
Equipment	Pads / briefs	LUQ bowel sounds	Hypoactive
LLQ bowel sounds	Hypoactive	RUQ bowel sounds	Hypoactive
RLQ bowel sounds	Hypoactive	G-tube / PEG tube	Yes

Genitourinary Assessment

Genitourinary	WDL except	Urine color	Pink tinged, Yellow
Aids to elimination	Catheter, indwelling	Urinary catheter present on admission	Indwelling urinary catheter inserted at WKHS
Date / Time Inserted	02/10/2018 06:00	Catheter type	Indwelling urinary
Catheter size	Other (specify)	Other catheter size	12F
External genitalia	WDL except	Female genitalia	Other (specify)

Pt Name: [REDACTED] L

MRN: 1116206

Assessment Report

Rm/ Bed:

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 DOB: 10/01/2013 Age/Sex: 4Y/F
 Adm DTime: 02/10/2018 09:11 Atn Dr: Do, Giao MD
 Nurs Sta: S 4 PICU Rm & Bed:
 Dx:
 Allrg: codeine, Fish Containing Products, Fish containing products

Urinary Catheter Discontinuation

Assessment Sts Complete Collected DTime 02/14/2018 04:12
 Collected By Jennifer L Hooker, RN

Urinary Catheter Discontinuation

Date/Time Catheter discontinued	02/14/2018 01:45	Catheter type	Indwelling urinary
Catheter size	Other (specify)	Other catheter size	12F
Balloon inflation volume	5 mL	Urine color	Yellow
Tolerated procedure	Good		

Clinical Note:

Urinary Catheter Insertion

Assessment Sts Complete Collected DTime 02/14/2018 04:12
 Collected By Jennifer L Hooker, RN

Urinary Catheter Insertion

Reason for Catheter Placement	Clinical need for accurate intake and output	Date / Time Inserted	02/14/2018 01:45
Catheter type	Indwelling urinary	Catheter size	Other (specify)
Other catheter size	10	Balloon inflation volume	3 mL
Urinary catheter present on admission	Indwelling urinary catheter inserted at WKHS		

Clinical Note:

Urinary Catheter Management - Indwelling

Assessment Sts Complete Collected DTime 02/16/2018 07:13
 Collected By Tiffany R Jemer, RN

Urinary Catheter Management - Indwelling

Urinary Catheter continuation qualifying criteria	Intake and output monitoring - when accurate measurements are required for the following patients: critically ill deemed hemodynamically unstable, unable to reliably collect urine measurements, receiving large volumes fluid and / or diuretics	Indwelling urinary catheter maintenance procedure completed	Yes
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Clinical Note:

Urinary Catheter Management - Indwelling

Assessment Sts Complete Collected DTime 02/15/2018 08:00
 Collected By Julie E Bolding, RN

Urinary Catheter Management - Indwelling

Pt Name: [REDACTED] L

MRN: 1116206

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Clinical Notes Report

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Pt Name:	██████████L	MRN:	1116206
Pt ID:	0101757329	Acct No:	K20034595213
DOB:	10/01/2013	Age/Sex:	4Y/F
Adm DTime:	02/10/2018 09:11	Attn Dr:	Do, Giao MD
Nurs Sta:	S 4 PICU	Rm & Bed:	
Dx:			
Alrg:	codeine, Fish Containing Products, Fish containing products		

Collected Date/Time: 02/15/18 17:32 Status: Complete

Collected By: Julie E Bolding, RN

Collected Date/Time: 02/15/18 17:08 Status: Complete

Collected By: Julie E Bolding, RN

Note: Spoke with LOPA again per Dr. DO - updating them that he plans to take her off life support in am. I spoke with Ms. Vickers again, updated her. She stated that LOPA rep would be here around 8:00-8:30 in the am.

Collected Date/Time: 02/15/18 16:30 Status: Complete

Collected By: Julie E Bolding, RN

Note: Spoke with LaSundra Prim - updated her on brain death studies today and planned for again in am.

1645 Spoke with Det Allday again - autopsy will definitely be done. Spoke with LOPA Ms. Vickers - She states that LOPA does preautopsy harvests all the time and work closely with the coroner. Dr. Do updated. All lab work and chest x-rays dc'd per Dr. Do.

Collected Date/Time: 02/15/18 15:15 Status: Complete

Collected By: Julie E Bolding, RN

Note: Detective Allday (834-8855) was called up update on Brain Death studies, last set to be performed by Dr. Do 2/16/18 am.

Attempt to contact CPS - LaSundra Prim - left message on voicemail at office and voicemail on cell phone.

Collected Date/Time: 02/15/18 14:09 Status: Complete

Collected By: Julie E Bolding, RN

Note: 1140 To NM for perfusion study of brain. Pt tolerated procedure well.

1240 Pt back to room, stable.

1300 Dr. Tran at BS with discussion concerning perfusion study and death studies about to be performed. Cold calorics, head tilt, corneal reflexes, and apnea challenge performed with CO2 in 90s.

1400 Dr. Tran spoke with family at length concerning results and outcomes. Family voiced understanding. Patient repositioned with pressure points. VSS.

Collected Date/Time: 02/14/18 14:04 Status: Complete

Collected By: Julie E Bolding, RN

Note: 1230 US of abdomen being done. EEG tech in room preparing for EEG.

Pt Name: ██████████L
Rm/ Bed:

MRN: 1116206
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Pt Name:	██████████ L	MRN:	1116206
Pt ID:	0101757329	Acct No:	K20034595213
DOB:	10/01/2013	Age/Sex:	4Y/F
Adm DTime:	02/10/2018 09:11	Atn Dr:	Do, Giao MD
Nurs Sta:	S 4 PICU	Rm & Bed:	
Dx:			
AIrg:	codeine, Fish Containing Products, Fish containing products		

Collected Date/Time: 02/14/18 14:04 Status: Complete

Collected By: Julie E Bolding, RN

1300 Fentanyl turned off.

1330 EEG completed.

Collected Date/Time: 02/14/18 13:51 Status: Complete

Collected By: Sandra D Williams

Note: EEG COMPLETE PT UNRESPONSIVE ON VENT. MOM DEMONSTRATES UNDERSTANDING. INFECTION CONTROL AND PAT SAFETY PROTOCOL WERE USED. NOTIFIED DR LITTLE UPON COMPLETION

Collected Date/Time: 02/14/18 11:00 Status: Complete

Collected By: Julie E Bolding, RN

Note: MD aware of elevated BPs - Fentanyl 15 mcg bolus given to see if BP would lower - no effect. Family at BS, updated on continued POC.

Collected Date/Time: 02/13/18 17:50 Status: Complete

Collected By: Tiffany R Jerner, RN

Note: Large area of swelling noted to pubic mound region and labia (more so pubic mound). IVF infusion without difficulty. Positive blood return from distal port. Foley care done.

Collected Date/Time: 02/13/18 13:10 Status: Complete

Collected By: Tiffany R Jerner, RN

Note: Before blood transfusion, distal port had been saline locked, flushed with 5 ml NS and clamped. When I attempted to restart IVFs, distal port would not flush or draw back blood. IVFs moved to medial port. Dr Tran notified. No new orders.

Collected Date/Time: 02/13/18 12:05 Status: Complete

Collected By: Tiffany R Jerner, RN

Note: FIO2 decreased per RT.

Collected Date/Time: 02/13/18 11:20 Status: Complete

Collected By: Tiffany R Jerner, RN

Pt Name: HENDERSON ██████████ L
Rm/ Bed:

MRN: 1116206
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Adm DTime: 02/10/2018 09:11 Atn Dr: Do, Giao MD
Nurs Sta: S 4 PICU Rm & Bed:
Dx:
Alrg: codeine, Fish Containing Products, Fish containing products

Collected Date/Time: 02/10/18 15:55 Status: Complete

Collected By: Robert D Timmons, LPN

Note: CT SCAN ORDERED c CONTRAST. pt HAS ALLERGY TO FISH CONTAINING PRODUCTS. NO PRE-MED ORDERED BY MD OR RADIOLOGIST.

Collected Date/Time: 02/10/18 09:50 Status: Complete

Collected By: Julie E Bolding, RN

Note: 0950 Patient arrived per EMS, bagging in progress. Patient placed on bed. Monitor connected. ETT possibly displaced on arrival - CO2 detector - no color change. Dr. Tran at BS. Heather, RT at BS. RNs X 2 at BS. ETT exchanged for a 6.0 cuffed ETT, with good color change, secured with Neobar at 18 at the lip. Patient placed on Servo Vent - see flowsheet for settings. R hand PIV with + flush. R leg IO - out, lying in gauze. Patient very cold and dry. No response to stimuli. NGT R nare exchanged for a 12 F NGT connected to ILWS - dark particulate drainage noted. CXR performed for placement of NGT and ETT. 6 French Foley was in place on arrival, had not drained anything to urimeter. Rocuronium 17 mg given IVP. Fentanyl drip started at 1 mg/kg. Lhand 22 gauge PIV started per R. Timmons, LPN II. MD noted skin tears at entrance to vagina. Denise (House Supervisor) informed. Denise called CPS, SPD. 5.5 13 cm TL CVL placed in R fem - Bolus of 1000 ml given per gravity. Blood obtained for lab and ISTAT. Bair Hugger placed for low temp (unable to read axillary and was not to use rectal due to SANE nurse coming for examination. 1 Amp D50 given at 1104 for OF of 43. Concentrated orange urine with small red blood clots noted draining to urimeter after the bolus.

1135 IVF (D5NS started at 65 ml/hr to CVL. Another bolus of NS 300 ml over 30 minutes given per MD order. 1315 ISTAT performed. 1425 Insulin drip at 0.05 units/hr started to R hand. 1445 Rocuronium drip started to CVL at 10.2 ml/hr. 1500 Bair Hugger off. Patient temp WNL.

1600 Patient to CT and back at 1630. BP decreased, Epi drip started at 15.9 ml/h. 1630 ISTAT. 1745 Calcium chloride started over 1 hour (105 ml). FFS (200 ml) given over 1 hour.

Pt Name: HENDERSON [REDACTED] L
Rm/ Bed:

MRN: 1116206
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Clinical Notes Report
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Physician Documentation

Willis Knighton South

Name: Aaliyah [REDACTED]
Age: 4 yrs Sex: Female DOB: 10/01/2013
Arrival Date: 02/10/2018 Time: 01:54
Bed 20

MRN: 1116206
Account#: K20034594943
Private MD: Allen, Scott

HPI:

02/10 This 4 yrs old Black/African Am Female presents to ED via Ambulatory with complaints of **Breathing** dre/mj2

02:33 Difficulty, Asthma Exacerbation

02:33 The patient presents to the emergency department with cough, wheezing. Onset: The symptoms/episode began/occurred at 00:00. Associated signs and symptoms: Pertinent positives: cough, wheezing, Pertinent negatives: abdominal pain, body aches, chest pain, constipation, diarrhea, dysuria, earache, fever, headache, myalgias, nasal discharge, seizure, sore throat, vomiting. Modifying factors: The patient symptoms are alleviated by nothing, the patient symptoms are aggravated by nothing. The patient has experienced a previous episode. The patient has been recently seen by a physician: SEEN AT QUICK CARE THURSDAY, DX WITH URI/STREP GIVEN Z PAK. HX AUTISM, ASTHMA, HAS BREATHING MACHINE AT HOME-ALBUTEROL, ONE TX PTA. dre/mj2

Historical:

- **Allergies:** Codeine; FISH PRODUCT DERIVATIVES;
- **Home Meds:**
 1. Albuterol Inhl as needed
 2. dulera 2 puffs am and 2 puffs pm
 3. Singulair PO nightly
- **PMHx:** Asthma; Autism
- **PSHx:** None

Historical:

02:11 Family history: No immediate family members are acutely ill. Immunization history: Childhood immunizations up to date, Last flu immunization: up to date. Social history: The patient lives at home with mother The patient attends nursery school the patient is a minor. sr11

02:33 The history from nurses notes was reviewed and confirmed. dre/mj2

ROS:

02:33 ROS as in the HPI, and all other systems were reviewed negative, or noncontributory, except as mentioned below. **Eyes:** Negative for injury, pain, redness, and discharge, **ENT:** Negative for injury, pain, and discharge, **Neck:** Negative for injury, pain, and swelling, **Cardiovascular:** Negative for chest pain, palpitations, and edema, **Abdomen/GI:** Negative for abdominal pain, nausea, vomiting, diarrhea, and constipation, **Back:** Negative for injury and pain, **GU:** Negative for injury, bleeding, discharge, and swelling, **MS/Extremity:** Negative for injury and deformity, **Skin:** Negative for injury, rash, and discoloration, **Neuro:** Negative for headache, weakness, numbness, tingling, and seizure. **Constitutional:** Positive for coughing, shortness of breath, Negative for chills, fatigue, malaise, acute pain, poor PO intake, vomiting, weight loss. **Respiratory:** Positive for cough, wheezing, Negative for dyspnea on exertion, hemoptysis, orthopnea, pleurisy, paroxysmal nocturnal dyspnea, sputum production. dre/mj2

Exam:

02:33 dre/mj2

Head/Face: Normocephalic, atraumatic.

Eyes: Pupils equal round and reactive to light, extra-ocular motions intact. Lids and lashes normal. Conjunctiva and sclera are non-icteric and not injected. Cornea within normal limits. Periorbital areas with no swelling, redness, or edema.

ENT: Nares patent. No nasal discharge, no septal abnormalities noted. Tympanic membranes are normal and external auditory canals are clear. Oropharynx with no redness, swelling, or masses, exudates, or evidence of obstruction, uvula midline. Mucous membrane moist

Neck: Trachea midline, no thyromegaly or masses palpated, and no cervical lymphadenopathy. Supple, full range of motion without nuchal rigidity, or vertebral point tenderness. No Meningismus. Lymphatic No abnormal lymphadenopathy noted by palpation in the neck or axilla

Chest/axilla: Normal symmetrical motion. No tenderness. No crepitus. No axillary masses or tenderness.

Physician Documentation Con't.

Cardiovascular: Regular rate and rhythm with normal S1 and S2. no murmurs, rubs or gallops. Pulses intact and symmetrical throughout. No edema or JVD.

Abdomen/GI: Soft, non-tender, nondistended, no mass, no hepatosplenomegaly. No rebound or guarding. Bowel sounds present all quadrants. No hernia noted

Back: No spinal tenderness. No costovertebral tenderness. Full range of motion.

Skin: Warm and dry with excellent turgor. capillary refill <2 seconds. No cyanosis, pallor, rash or edema.

MS/ Extremity: Pulses equal, no cyanosis. Neurovascular intact. Joints show full, normal range of motion. Good muscle tone and strength. No acute changes of nails or digits

Neuro: Awake or easily awakened, alert, makes good eye contact, age appropriate reflexes, good tone, easily consolable.

Constitutional: The patient appears Blood pressure, pulse, respirations and temperature noted. awake, alert, well developed, well groomed, well hydrated, well nourished, non-diaphoretic, non-toxic, afebrile.

Respiratory: the patient does not display signs of respiratory distress. Respirations: normal, symmetrical, no use of accessory muscles, no grunting, no evidence of nasal flaring, no appreciated paradoxical movements, no prolonged exhalations, no pursed lip breathing, no retractions, no shallow respirations, no splinting, no tachypnea, Breath sounds: rales, are not appreciated, rhonchi, are not appreciated, wheezing, that is mild, bronchial sounds, are not appreciated, decreased breath sounds, are not appreciated, stridor, is not appreciated.

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Height	Pain	Staff
02:05		156	36	99.3	91 % on R/A	18.14 kg / 39 lbs 16 oz	3 ft. 2 in. (96.52 cm)		sr11
03:23		145	34		99%				sr11

02:05 Body Mass Index 19.47 (18.14 kg, 96.52 cm)

02:05 100% breathing treatment

sr11

sr11

Glasgow Coma Score:

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
02:05	spontaneous(4)	oriented(5)	obeys commands(6)		15	sr11

MDM:

02:30 Patient medically screened.

02:33

dre

dre/mj2

Data interpreted: Pulse oximetry: on room air observed by me at the bedside is 91 %.

03:50

dre

Differential diagnosis: bacterial infection, bronchitis, fever, gastroenteritis, pneumonia URI, UTI, viral Infection.

Data reviewed: vital signs, nurses notes, lab test result(s), radiologic studies.

Counseling: I had a detailed discussion with the patient and/or guardian regarding: the historical points, exam findings, and any diagnostic results supporting the discharge/admit diagnosis, lab results, radiology results, the need for outpatient follow up.

Response to treatment: the patient's symptoms have resolved after treatment, the patient's condition has returned to base line.

Order	Status	Time	By	For
DuoNeb 1 unit dose Inhalation once	Ordered	02/10/18 02:04	sr11	dre
	Administered	02/10/18 02:04	sr11	
Notes:	Order Method: Verbal - Read back			
	Sign off: Easterling, David, MD 02/10/18 02:31			

Name: Aaliyah [REDACTED]

MRN: 1116206

Account#: K20034594943

Print Time: 2/11/2018 06:00:37

Page 2 of 4.

Physician Documentation Con't.

Drug alert over ride reasons: Clinically indicated				
02/10/18 02:04		Administered: DuoNeb 1 unit dose Inhalation		sr11
02/10/18 02:32		Follow Up: Response: No Adverse Reaction; Respiratory status improved; Tolerated well		sr11
Order	Status	Time	By	For
Influenza by PCR	Ordered	02/10/18 02:31	dre	dre
	Reviewed	02/10/18 03:10	David Easterling	
Notes:		Order Method: Electronic		
Interpretation: negative.				
Ordering Location: ERSPC100.1				
Priority LAB: Stat				
Collected by Nurse? (Yes - Change to No for Lab Collect): Yes				
Specimen Source (LBFLUSPEC): Nasopharynx				
Order	Status	Time	By	For
COLLECT SWAB	Ordered	02/10/18 02:31	dre	dre
	Completed	02/10/18 02:32	Susan Rainer	
Notes:		Order Method: Electronic		
Order	Status	Time	By	For
Chest 2 View *routine*	Ordered	02/10/18 02:31	dre	dre
	In Process Unspecified	02/10/18 03:39	Dispatcher MedHost	
Notes: Bed Name: 20		Order Method: Electronic		
Interpretation: perihilar infiltrates, otherwise negative.				
Is the patient able to bear weight? (OERDBEARWT):				
Is the patient at risk for falls? (OERDFALLS):				
MODE OF TRANSPORTATION : (OERDTRANS): Stretcher				
O2: (OEADO2): No				
Priority RAD: Stat				
REASON FOR EXAM: (OERDEXAM): Breathing Difficulty, Asthma Exacerbation				
WEIGHT? : (OERDWEIGHT): 18.14				
ER EXAM ROOM/BED: (OERDERRMBD): 20				
Order	Status	Time	By	For
Call X-Ray Tech	Ordered	02/10/18 02:31	dre	dre
	Completed	02/10/18 02:36	Susan Rainer	
Notes:		Order Method: Electronic		
Order	Status	Time	By	For
Albuterol One Unit Dose (6kg & up) - Albuterol 2.5 mg Inhalation once	Ordered	02/10/18 03:11	dre	dre
	Administered	02/10/18 03:16	sr11	
Notes:		Order Method: Electronic		

Name: Aaliyah

MRN: 1116206

Account#: K20034594943

Print Time: 2/11/2018 06:00:37

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Physician Documentation Con't.

02/10/18 03:16 Administered: Albuterol One Unit Dose (6kg & up) - Albuterol 2.5 mg Inhalation		sr11		
02/10/18 03:55 Follow Up: Response: No Adverse Reaction; Respiratory status improved; Tolerated well		sr11		
Order	Status	Time	By	For
Decadron - Dexamethasone Sodium Phosphate 4 mg IM once	Ordered	02/10/18 03:12	dre	dre
	Administered	02/10/18 03:44	mh7	
Notes:	Order Method: Electronic			
02/10/18 03:44 Administered: Decadron - Dexamethasone Sodium Phosphate 4 mg IM in left ventrogluteal		mh7		
02/10/18 04:00 Follow Up: Response: No Adverse Reaction; Tolerated well		sr11		

Order Signatures:

Easterling, David, MD MD dre Rainer, Susan, RN RN sr11

Scribe Statement:

02/10
02:13 Scribed for **Dr. David R Easterling, MD** by Morgan Jaudon, Scribe dre/mj2

Disposition:

03:50 Electronically signed by: David Easterling, M.D. I personally performed the services described in this documentation as scribed in my presence and it is both accurate and complete. Disposition. dre

Disposition:

02/10/18 03:52 Discharged to Home/Self Care. Impression: Acute bronchospasm.

- Condition is Stable.
- Discharge Instructions: Bronchospasm, Pediatric.
- Prescriptions for prednisolone 15 mg/5 mL Oral Solution
 - take 10 milliliter by ORAL route once daily for 5 days with food; 50 milliliter.
- Follow up: Allen, Scott; When: 2 days; Reason: Recheck today's complaints.
- Problem is an acute exacerbation.
- Symptoms are resolved.

Signatures:

Dispatcher MedHost EDMS Easterling, David, MD MD dre
Jaudon, Morgan, Scribe Scribe mj2 Harmon, Melissa, RN RN mh7
Rainer, Susan, RN RN sr11

Corrections:

03:52 ~~02/10/2018 03:52 Discharged to Home/Self Care. Impression: Acute bronchospasm. Condition is Stable. Follow up: Scott Allen; When: 2 days; Reason: Recheck today's complaints. Problem is an acute exacerbation. Symptoms are resolved.~~ dre dre

Name: Aaliyah [REDACTED]

MRN: 1116206

Account#: K20034594943

Print Time: 2/11/2018 06:00:37

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Nurse's Notes

Name: Aaliyah
Age: 4 yrs Sex: Female DOB: 10/01/2013
Arrival Date: 02/10/2018 Time: 01:54
Bed 20

Willis Knighton South

MRN: 1116206
Account#: K20034594943
Private MD: Allen, Scott

Presentation:

02/10 Preferred language for medical communication is English. Presenting complaint: Mother states: woke up at 02:05 midnight wheezing and coughing, i took her to quick care the other day, she has strep throat and URI, shes been taking a z pack, gave breathing treatment at home with no relief, pt currently sitting in tripod position. Person Transporting: Parent. Transition of care: patient was not received from another setting of care. Mechanism of Injury: denies injury. Care prior to arrival: Medications: Albuterol Neb.
02:11 Acuity: 2 - Emergent. sr11
02:15 Method of Arrival: Ambulatory. sr11

Triage Assessment:

02:05 **General:** Appears well developed, well nourished, well groomed, distressed, uncomfortable, Behavior is appropriate for age, anxious, mobility; ambulates without assistance. **Pain:** level that is acceptable is 0 out of 10 on a pain scale. sr11

Historical:

- **Allergies:** Codeine; FISH PRODUCT DERIVATIVES;
- **Home Meds:**
 1. Albuterol Inhl as needed
 2. dulera 2 puffs am and 2 puffs pm
 3. Singulair PO nightly
- **PMHx:** Asthma; Autism
- **PSHx:** None

Historical:

02:11 Family history: No immediate family members are acutely ill. Immunization history: Childhood immunizations up to date, Last flu immunization: up to date. Social history: The patient lives at home with mother The patient attends nursery school the patient is a minor. sr11

02:33 The history from nurses notes was reviewed and confirmed. dre/mj2

Screening:

02:05 **Abuse screen:** sr11
Denies threats or abuse. Denies injuries from another. there are no obvious signs of child abuse.
Patient fall risk assessment;
No risks identified.
Learning Barriers:
No barriers to teaching and learning identified.
Pedi Fall Risk
No risks identified.
Exposure risk/Travel Screening:
No exposures identified.

Assessment:

02:11 **Pain:** Denies pain. level that is acceptable is 0 out of 10 on a pain scale. **General:** Appears well developed, well nourished, well groomed, distressed, uncomfortable, Behavior is appropriate for age, anxious, mobility; ambulates without assistance. **Neuro:** Level of Consciousness is alert, awake, obeys commands. **EENT:** Reports Sore Throat Parent/caregiver reports the patient having nasal congestion nasal discharge. **Cardiovascular:** Capillary refill < 3 seconds is brisk in bilateral fingers Rhythm is sinus tachycardia. **Respiratory:** Respiratory effort is labored, with retractions, using tripod position, Respiratory pattern is tachypnea Airway is patent Breath sounds with wheezes bilaterally. **Dermatologic:** Skin is intact, is healthy with good turgor, Skin is pink, warm & dry. normal. sr11

02:33 **Respiratory:** Reassessment: Patient states symptoms have improved. sr11

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Height	Pain	Staff
02:05		156	36	99.3	91% on R/A	18.14 kg / 39 lbs 16 oz	3 ft. 2 in. (96.52 cm)		sr11
03:23		145	34		99%				sr11

02:05 Body Mass Index 19.47 (18.14 kg, 96.52 cm)

sr11

Nurse's Notes Con't

02:05 100% breathing treatment

sr11

Vitals:

02:05 Acuity: 2 - Emergent.

sr11

Glasgow Coma Score:

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
02:05	spontaneous(4)	oriented(5)	obeys commands(6)		15	sr11

ED Course:

01:54 Patient arrived in ED. ms2
 01:54 Patient moved to KIOSK. ms2
 02:04 Patient moved to 20. sr11
 02:04 Rainer, Susan, RN is Primary Nurse. sr11
 02:11 Triage completed. sr11
 02:11 Patient/caregiver encouraged to voice any concerns. Side rails up X 1. Bed in low position. Child being held by parent. Pulse oximetry, Bedside monitor alarms on and audible. sr11
 02:13 Easterling, David, MD is Attending Physician. dre
 02:15 Allen, Scott is Private Physician. sr11
 02:33 Influenza culture sent to lab. sr11
 02:46 Patient moved to Radiology. jat
 02:46 Chest 2 View *routine* Sent. jat
 03:29 Patient moved to 20. jat
 03:51 Allen, Scott is Referral Physician. dre
 03:59 No procedures done that require assistance. sr11

Administered Medications:

Time	Drug & Dose <i>Dispensable & Quantity</i>	Volume	Route	Rate	Infused Over	Site	Delivery	Staff
02:04	DuoNeb 1 unit dose		Inhalation					sr11
02:32	Follow up: Response: No Adverse Reaction; Respiratory status improved; Tolerated well							sr11
03:16	Albuterol One Unit Dose (6kg & up) - Albuterol 2.5 mg		Inhalation					sr11
03:55	Follow up: Response: No Adverse Reaction; Respiratory status improved; Tolerated well							sr11
03:44	Decadron - Dexamethasone Sodium Phosphate 4 mg		IM			left ventrogluteal		mh7
04:00	Follow up: Response: No Adverse Reaction; Tolerated well							sr11

Outcome:

03:52 Discharge ordered by MD. dre
 03:59 Discharged to home, ambulatory, with family. Discharge instructions given to Mother Instructed on discharge instructions, follow up and referral plans, medication usage, Demonstrated understanding of instructions, medications, Prescriptions given; 1, No questions or concerns expressed to me at discharge. No belongings were removed by WK staff. **Medication reconcilliation form provided. Med Effects:** Effects of administered medications were addressed. **Oxygen use:** Oxygen use not applicable. sr11

Name: Aaliyah [REDACTED]

MRN: 1116206

Account#: K20034594943

Print Time: 2/11/2018 06:00:36

Page 2 of 3

Nurse's Notes Con't

04:00 Electronic medical record closed.

sr11

Signatures:

Easterling, David, MD	MD	dre	Scriptuser, MEDHOST	ms2
Torres, Jose		jat	Jaudon, Morgan, Scribe	Scribe mj2
Harmon, Melissa, RN	RN	mh7	Rainer, Susan, RN	RN sr11

Corrections:

02:20 02:05 ~~Pulse 156bpm; Resp 36bpm; Pulse Ox 91% RA; 18.14 kg; Height 3 ft. 2 in.; BMI: 19.4; 100% breathing treatment;~~

sr11 sr11

02:22 02:14 ~~Respiratory: Respiratory effort is labored, with retractions, grunting, using tripod position; Respiratory pattern is tachypnea Airway is patent Breath sounds with wheezes bilaterally.~~

sr11 sr11

Name: Aaliyah [REDACTED]

Print Time: 2/11/2018 06:00:36

MRN: 1116206
Account#: K20034594943
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Physician Documentation

Willis Knighton South

Name: Aaliyah [REDACTED]
Age: 4 yrs Sex: Female DOB: 10/01/2013
Arrival Date: 12/06/2017 Time: 08:03
Bed Post IM4

MRN: 1116206
Account#: K20034364339
Private MD:

HPI:

12/06 This 4 yrs old Black/African Am Female presents to ED via Ambulatory with complaints of **Cough**. ah/ib
08:35
08:35 The patient presents to the emergency department with cough, described as mild, with productive sputum, fever, with an emergency department temperature of 98.6 degrees Fahrenheit. Onset: The symptoms/episode began/occurred 3 day(s) ago. Associated signs and symptoms: Pertinent positives: cough, fever, Pertinent negatives: abdominal pain, body aches, chest pain, congestion, constipation, diarrhea, dysuria, earache, headache, myalgias, nasal discharge, seizure, shortness of breath, sore throat, vomiting, wheezing. Modifying factors: The patient symptoms are alleviated by nothing, the patient symptoms are aggravated by nothing. Treatment prior to arrival: none. The patient has not experienced similar symptoms in the past. The patient has been recently seen by a physician: a pulmonologist, 2 day(s) ago, with different complaint(s), and apparently was diagnosed with Ear infection. ah/ib

Historical:

- **Allergies:** Codeine; seafood; FISH PRODUCT DERIVATIVES (Hives); SEA FOOD;
- **Home Meds:**
 1. Albuterol Unknown Inhl Unknown as needed.
 2. Dulera 100-5 mcg/actuation inhalation [REDACTED] 2 puffs 2 times per day
 3. Singulair 5 mg PO chew once daily
- **PMHx:** Asthma; Autism
- **PSHx:** None

Historical:

08:22 Family history: Pertinent for; diabetes, hypertension. Immunization history: Childhood immunizations up to date. Last flu immunization: up to date. Last tetanus immunization: up to date. Social history: the patient is a minor. ar6
08:37 The history from nurses notes was reviewed and confirmed. ah/ib

ROS:

08:37 ROS as in the HPI, and all other systems were reviewed negative, or noncontributory, except as mentioned below. **Eyes:** Negative for injury, pain, redness, and discharge, **ENT:** Negative for injury, pain, and discharge, **Neck:** Negative for injury, pain, and swelling, **Cardiovascular:** Negative for chest pain, palpitations, and edema, **Abdomen/GI:** Negative for abdominal pain, nausea, vomiting, diarrhea, and constipation, **Back:** Negative for injury and pain, **GU:** Negative for injury, bleeding, discharge, and swelling, **MS/Extremity:** Negative for injury and deformity, **Skin:** Negative for injury, rash, and discoloration, **Neuro:** Negative for headache, weakness, numbness, tingling, and seizure, **Psych:** Negative for depression, anxiety, suicide ideation, homicidal ideation, and hallucinations. **Constitutional:** Positive for coughing, fever, Negative for body aches, chills, obvious distress, acute pain, poor PO intake, shortness of breath, vomiting. **Respiratory:** Positive for cough, "sounds productive", Negative for hemoptysis, orthopnea, pleurisy, shortness of breath, wheezing. ah/ib

Exam:

08:37 ah/ib
Head/Face: Normocephalic; atraumatic.
Eyes: Pupils equal round and reactive to light, extra-ocular motions intact. Lids and lashes normal. Conjunctiva and sclera are non-icteric and not injected. Cornea within normal limits. Periorbital areas with no swelling, redness, or edema.
Neck: Trachea midline, no cervical lymphadenopathy. Supple, full range of motion without nuchal rigidity, or vertebral point tenderness. No Meningismus. Lymphatic No abnormal lymphadenopathy noted by palpation in the neck or axilla
Chest/axilla: Normal symmetrical motion. No tenderness. No crepitus.
Cardiovascular: Regular rate and rhythm with a normal S1 and S2. No gallops, murmurs, or rubs. No JVD.

Physician Documentation Con't.

No pulse deficits.

Abdomen/GI: Soft, non-tender with normal bowel sounds. No distension. No guarding, rebound or rigidity. No palpable masses or evidence of tenderness with thorough palpation.

Back: No spinal tenderness. No costovertebral tenderness. Full range of motion.

Skin: Warm and dry with excellent turgor. capillary refill <2 seconds. No cyanosis, pallor, rash or edema.

MS/ Extremity: Pulses equal, no cyanosis. Neurovascular intact. Full, normal range of motion.

Neuro: Awake and alert, GCS 15. Good muscle tone. Moves all extremities. Sensory grossly intact. Age appropriate reflexes and responses to physical exam.

Psych: Behavior, mood, response, and affect are appropriate for age.

Constitutional: The patient appears Blood pressure, pulse, respirations and temperature noted. awake, alert, well developed, well hydrated, well nourished, non-diaphoretic, non-toxic, afebrile.

ENT:

External ear(s): are unremarkable, no abrasion, no avulsion, no erythema, no laceration, no puncture, no cellulitis, no abscess, no swelling, no contusion, no pain with movement.

Ear canal(s): are normal, clear, no abscess, no bleeding, no bloody discharge, no cerumen impaction, no erythema, no foreign body, no purulent discharge, no swelling,

TM's: bulging, is not appreciated, decreased mobility, is not appreciated, dullness, is not appreciated, erythema, that is mild, bilaterally, fluid levels, is not appreciated, hemotympanum, is not appreciated, loss of bony landmarks, is not appreciated, rupture, is not appreciated,

Nose: Nasal septum: Nasal mucosa: normal, Turbinates: are normal, abrasion, is not appreciated, bleeding, is not appreciated, nasal drainage, that is minimal, and is seen coming from both nares, crusted exudate a foreign body, is not appreciated, laceration, is not appreciated,

Mouth: is normal, no gum abnormalities, no lip abnormalities, no mucosal abnormalities, no tongue abnormalities,

Posterior pharynx: is normal, airway is patent, no erythema, no exudate, no peritonsillar mass, no pooling of secretions, no swelling,

Respiratory: the patient does not display signs of respiratory distress, Respirations: normal, symmetrical, no use of accessory muscles, no grunting, no evidence of nasal flaring, no appreciated paradoxical movements, no prolonged exhalations, no pursed lip breathing, no retractions, no shallow respirations, no splinting, no tachypnea, Breath sounds: rales, are not appreciated, rhonchi, are not appreciated, crackles, are not appreciated, wheezing, that is mild, is heard diffusely, Expiratory, bronchial sounds, are not appreciated, decreased breath sounds, are not appreciated, stridor, is not appreciated.

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Height	Pain	Staff
08:07		144	26	98.6(TE)	100% on R/A	16.33 kg / 36 lbs 0 oz	3 ft. 2 in. (96.52 cm)	0/10	lc4
08:53		121							ar6

08:07 Body Mass Index 17.53 (16.33 kg, 96.52 cm)

lc4

Glasgow Coma Score:

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
08:07	spontaneous(4)	oriented(5)	obeys commands(6)		15	lc4

MDM:

08:34 Patient medically screened.

ah

09:42

ah

Data reviewed: vital signs, nurses notes.

Counseling: I had a detailed discussion with the patient and/or guardian regarding: the historical points, exam findings, and any diagnostic results supporting the discharge/admit diagnosis, radiology results, the need for outpatient follow up, to return to the emergency department if symptoms worsen or persist or if there are any questions or concerns that arise at home.

Name: Aaliyah [REDACTED]

MRN: 1116206

Account#: K20034364339

Print Time: 12/7/2017 11:51:22

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Physician Documentation Con't.

Order	Status	Time	By	For
DuoNeb 1 unit dose Inhalation once	Ordered	12/06/17 08:36	ah	ah
	Administered	12/06/17 08:53	ar6	
Notes:	Order Method: Electronic			
Drug alert over ride reasons: MD discretion				
12/06/17 08:53	Administered: DuoNeb 1 unit dose Inhalation			ar6
12/06/17 09:49	Follow Up: Response: No Adverse Reaction; Respiratory status improved; Reassessment at discharge			ar6
Order	Status	Time	By	For
Chest Xray Portable 1 View	Ordered	12/06/17 08:36	ah	ah
	Reviewed	12/06/17 09:41	Andrew Haynes	
Notes: Bed Name: 7	Order Method: Electronic			
Interpretation: No acute disease.				
Is the patient able to bear weight? (OERDBEARWT):				
Is the patient at risk for falls? (OERDFALLS):				
MODE OF TRANSPORTATION : (OERDTRANS): Stretcher				
O2: (OEADO2): No				
Priority RAD: Stat				
REASON FOR EXAM: (OERDEXAM): Cough				
SPECIFIC TIME TO BE DONE: (OERDSPECTI): STAT				
WEIGHT? : (OERDWEIGHT): 16.33				
ER EXAM ROOM/BED: (OERDERRMBD): 7				
Order	Status	Time	By	For
Call X-Ray Tech	Ordered	12/06/17 08:36	ah	ah
	Completed	12/06/17 08:38	Marchelle Kelley	
Notes:	Order Method: Electronic			

Order Signatures:

Haynes, Andrew, MD MD ah

Scribe Statement:

12/06
08:34 Scribed for **Dr. Andrew Haynes, MD** by Ideal Bekteshi, Scribe ah/ib

Disposition:

09:42 Electronically signed by: Andrew Haynes M.D. I personally performed the services described in this documentation as scribed in my presence and it is both accurate and complete. Disposition. ah

Disposition:

12/06/17 09:43 Discharged to Home/Self Care. Impression: URI, Asthma.

- Condition is Stable.
- Discharge Instructions: Upper Respiratory Infection, Pediatric.

Name: Aaliyah [REDACTED]

MRN: 1116206
Account#: K20034364339

Physician Documentation Con't.

- Prescriptions for
Albuterol Sulfate 2.5 mg /3 mL (0.083 %) Inhalation Solution for Nebulization
- inhale 1 unit by NEBULIZATION route every 8 hours As needed; 1 box.
Prednisolone 15 mg/5 mL Oral Solution
- take 10 milliliter by ORAL route once daily for 5 days with food; 55 milliliter.
- School release in 3 days form.
- Follow up: Private Physician; When: 2 days.
- Problem is new.
- Symptoms have improved.

Signatures:

Dispatcher MedHost	EDMS	Haynes, Andrew, MD	MD	ah
Crawford, Lauren, RN	RN	lo4	Bekteshi, Ideal, Scribe	Scribe ib
Kelley, Marchelle, ED Tech	ED Tech	mk3	Rose, Amanda, RN	RN
				ar6

Corrections:

08:43 08:37 ENT: External ear(s): are unremarkable, no abrasion, no avulsion, no erythema, no laceration, no puncture, no cellulitis, no abscess, no swelling, no contusion, no pain with movement. Ear canal(s): are normal, clear, no abscess, no bleeding, no bloody discharge, no cerumen impaction, no erythema, no foreign body, no purulent discharge, no swelling, TM's: bulging, is not appreciated, decreased mobility, is not appreciated, dullness, is not appreciated, erythema, that is mild, bilaterally, fluid levels, is not appreciated, hemotympanum, is not appreciated, loss of bony landmarks, is not appreciated, rupture, is not appreciated, Nose: is normal, no abrasion, no abscess, no bleeding, no clotted blood, no contusion, no drainage, no edema, no erythema, no laceration, no septal hematoma, no swelling, Mouth: is normal, no gum abnormalities, no lip abnormalities, no mucosal abnormalities, no tongue abnormalities, Posterior pharynx: is normal, airway is patent, no erythema, no exudate, no peritonsillar mass, no pooling of secretions, no swelling, ah/ib ah/ib

08:43 08:37 Head/Face: Normocephalic, atraumatic. Eyes: Pupils equal round and reactive to light, extra-ocular motions intact. Lids and lashes normal. Conjunctiva and sclera are non-icteric and not injected. Cornea within normal limits. Periorbital areas with no swelling, redness, or edema. Neck: Trachea midline, no cervical lymphadenopathy. Supple, full range of motion without nuchal rigidity, or vertebral point tenderness. No Meningismus. Lymphatic No abnormal lymphadenopathy noted by palpation in the neck or axilla Chest/axilla: Normal symmetrical motion. No tenderness. No crepitus. Cardiovascular: Regular rate and rhythm with a normal S1 and S2. No gallops, murmurs, or rubs. No JVD. No pulse deficits. Abdomen/CI: Soft, non-tender with normal bowel sounds. No distension. No guarding, rebound or rigidity. No palpable masses or evidence of tenderness with thorough palpation. Back: No spinal tenderness. No costovertebral tenderness. Full range of motion. Skin: Warm and dry with excellent turgor: capillary refill <2 seconds. No cyanosis, pallor, rash or edema. MS/Extremity: Pulses equal, no cyanosis. Neurovascular intact. Full, normal range of motion. Neuro: Awake and alert, GCS 15. Good muscle tone. Moves all extremities. Sensory grossly intact. Age appropriate reflexes and responses to physical exam. Psych: Behavior, mood, response, and affect are appropriate for age. ah/ib ah/ib

09:50 09:43 12/06/2017 09:43 Discharged to Home/Self Care. Impression: URI, Asthma. Condition is Stable. Follow up: Private Physician; When: 2 days. Problem is new. Symptoms have improved. ah ar6

Name: Aaliyah [REDACTED]

MRN: 1116206
Account#: K20034364339
Page 4 of 4

Nurse's Notes

Name: Aaliyah [REDACTED]
Age: 4 yrs **Sex:** Female **DOB:** 10/01/2013
Arrival Date: 12/06/2017 **Time:** 08:03
Bed Post IM4

Willis Knighton South

MRN: 1116206
Account#: K20034364339
Private MD:

Presentation:

12/06 [REDACTED] lc4
 08:07 Method of Arrival: Ambulatory.
 08:07 Preferred language for medical communication is English. Presenting complaint: Mother states: "She is coughing and coughing up cold, she had fever yesterday. I took her to her pulmonologist on Monday and they found out she had an ear infection so they put her on antibiotics for that. She was throwing up cold yesterday". Person Transporting: Parent. Transition of care: patient was not received from another setting of care. lc4
 08:13 Acuity: 4 - Semi-Urgent. lc4

Triage Assessment:

08:07 **General:** Appears in no apparent distress, Behavior is cooperative. **Pain:** FACES pain scale score is 0 out of 10. lc4

Historical:

- **Allergies:** Codeine; seafood; FISH PRODUCT DERIVATIVES (Hives); SEA FOOD;
- **Home Meds:**
 1. Albuterol Unknown Inhl Unknown as needed
 2. Dulera 100-5 mcg/actuation inhalation [REDACTED] 2 puffs 2 times per day
 3. Singulair 5 mg PO chew once daily
- **PMHx:** Asthma; Autism
- **PSHx:** None

Historical:

08:22 Family history: Pertinent for; diabetes, hypertension. Immunization history: Childhood immunizations up to date. Last flu immunization: up to date. Last tetanus immunization: up to date. Social history: the patient is a minor. ar6
 08:37 The history from nurses notes was reviewed and confirmed. ah/ib

Screening:

08:07 **Abuse screen:** lc4
 Denies threats or abuse. Denies injuries from another.
Patient fall risk assessment;
 risks identified; None.
Learning Barriers:
 autism.
Pedi Fall Risk
 None Identified.
Exposure risk/Travel Screening:
 None identified.

Assessment:

08:22 **Pain:** level that is acceptable is 0 out of 10 on a pain scale. Faces, Legs, Activity, Cry, Consolability scale score is 0 out of 10. **General:** Appears in no apparent distress; well developed, well nourished, well groomed, Behavior is cooperative, appropriate for age, Reports MOM REPORTS "YESTERDAY SHE STARTED THROWING UP AND BEEN COUGHING EVER SINCE AND SHE HAD A FEVER. MONDAY SHE HAD A PULMONARY APPT AND THEY DIAGNOSED HER WITH AN EAR INFECTION. SHE IS TAKING AMOXICILLIN. BUT SHE WASN'T COUGHING THEN". **Neuro:** Level of Consciousness is alert, awake. **EENT:** Nares DRIED MUCOUS NOTED TO NARES BILATERALLY. **Cardiovascular:** Heart tones S1 S2 present. **Respiratory:** Respiratory effort is even, unlabored, relaxed, Respiratory pattern is regular, symmetrical, Airway is patent Breath sounds are clear bilaterally. **Gastrointestinal:** Parent/caregiver reports the patient having VOMITTING X 1 YESTERDAY. NONE TODAY. **Genitourinary:** Parent/caregiver reports the patient having normal urinary habits. **Dermatologic:** Skin is intact, is healthy with good turgor, Skin is pink, warm & dry. normal. **Musculoskeletal:** No deficits noted. **Injury Description:** denies injury. ar6

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Height	Pain	Staff
08:07		144	26	98.6(TE)	100% on R/A	16.33 kg /	3 ft. 2 in.	0/10	lc4

Nurse's Notes Con't

						36 lbs 0 oz	(96.52 cm)		
08:53		121							ar6
08:07	Body Mass Index 17.53 (16.33 kg, 96.52 cm)								lc4

Vitals:

08:07 Acuity: 4 - Semi-Urgent.

lc4

Glasgow Coma Score:

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
08:07	spontaneous(4)	oriented(5)	obeys commands(6)		15	lc4

ED Course:

08:03 Patient arrived in ED.

ms2

08:03 Patient moved to KIOSK.

ms2

08:12 Rose, Amanda, RN is Primary Nurse.

ar6

08:12 Patient moved to 7.

ar6

08:13 Triage completed.

lc4

08:17 Haynes, Andrew, MD is Attending Physician.

ah

08:22 Patient/caregiver encouraged to voice any concerns. Side rails up X 1. Bed in low position. Call light in reach. Instructed to call for assist when getting up, verbalized understanding. Patient has correct armband on for positive identification. Adult with patient. Pulse oximetry, Bedside monitor alarms on and audible.

ar6

09:49 Patient moved to Post IM4.

ar6

09:50 No procedures done that require assistance.

ar6

Administered Medications:

Time	Drug & Dose <i>Dispensable & Quantity</i>	Volume	Route	Rate	Infused Over	Site	Delivery	Staff
08:53	DuoNeb 1 unit dose		Inhalation					ar6
09:49	Follow up: Response: No Adverse Reaction; Respiratory status improved; Reassessment at discharge							ar6

Outcome:

09:43 Discharge ordered by MD.

ah

09:50 Discharged to home, ambulatory, with family. Discharge instructions given to Mother Instructed on discharge instructions, follow up and referral plans, medication usage, Demonstrated understanding of instructions, medications, Prescriptions given; 2, No questions or concerns expressed to me at discharge. School excuse given for 3day(s). No belongings were removed by WK staff. **Medication reconciliation form provided.**

ar6

Med Effects: Effects of administered medications were addressed. **Oxygen use:** Oxygen used on this visit.

09:50 Electronic medical record closed.

ar6

Signatures:

Haynes, Andrew, MD

MD ah

Scriptuser, MEDHOST

ms2

Crawford, Lauren, RN

RN lc4

Bekteshi, Ideal, Scribe

Scribe ib

Rose, Amanda, RN

RN ar6

Name: Aaliyah [REDACTED]

MRN: 1116206

Account#: K20034364339

Print Time: 12/7/2017 11:51:20

Page 2 of 2

Willis-Knighton South
2510 Bert Kouns Industrial Loop
Shreveport, LA 71118

Patient Name: [REDACTED]
Adm No: K20034364339
DOB: 10/01/2013
Age: 4Y F
Corp ID: 000001116206

MRN: 1116206
Location: ER Patient - -
Ord No: 90021
Hospital: WKS

Ordering Dr: ANDREW THOMAS HAYNES

CC:

Final Report

Admitting Diagnosis: COUGH
Reason For Exam: Cough
Procedure Date: 12/06/2017
Procedure: SXR - XR, chest 1 view portable

Interpretive Location: WKS
Accession Number: 3881039
CPT Code: 71010

IMPRESSION: Hazy bilateral perihilar infiltrates

RESULT:

Procedure: XR, chest 1 view portable

Clinical Information: Cough

Comparison: None.

Findings:

Bilateral hazy perihilar pulmonary infiltrates. Shallow ventilation. Appearance the chest worsened since last exam.

Electronically Signed by: WAYNE JOSEPH HOMZA M.D. on Dec 6 2017 9:52A

Techs: Cortney B Roshto Jaime S Rivers
Additional Staff:

Read by: WAYNE JOSEPH HOMZA M.D. on Dec 6 2017 9:52A
Electronically Signed by: WAYNE JOSEPH HOMZA M.D. on Dec 6 2017 9:52A

Printed: Dec 6 2017 9:56AM

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ALLERGY REPORT

Pt Name: [REDACTED] L MRN: 1116206
Pt ID: 0101757329 Acct No: K20034364339
DOB: 10/01/2013 Age/Sex: 4Y/F
Adm DTime: 12/06/2017 08:03 Attn Dr: Haynes, Andrew MD
Nurs Sta: Willis-Knighton South Rm & Bed:
Dx:
Alerg: codeine, Fish Containing Products, Fish containing products

Alerg Type	Alerg Name	Onset	Reaction	Severity	Comment
Drug	codeine	7/14/2017	Shortness of Breath	Severe	"Took codeine yesterday. Started wheezing, couldn't breathe like she was having an asthma attack"
Drug	Fish Containing Products	05/2017	Anaphylaxis	Severe	Patient severely allergic. Reaction when touches seafood
Food	Fish containing products	05/2017	Anaphylaxis	Severe	Patient severely allergic. Reaction when touches seafood

Pt Name: [REDACTED] L

MRN: 1116206

Allergy Report

Rm/ Bed:

Page 1 of 1

ORE_0109_DSCH_NBR.rpt v1.00

RUN DATE: 12/06/17
RUN TIME: 0813
RUN USER: HARTJ.AM

Willis Knighton with *ADMISSION
INTERDISCIPLINARY ALLERGY SOURCE DOCUMENT

PAGE 1

Name: [REDACTED] L DOB: 10/01/13 Age: 4Y 02M
Rm/Bd: Serv/Locn: ERS Status: ER Sex: F
Unit#: K000629604 Account#: K20034364339 EPI#: 000000001116206

Last Update/
Acknowledgement:

Interdisciplinary Assessment (Free Text), historical data:

Allergy1-Med/Contact: NKDA	11/04/16 - 2201
Allergy2-Med/Contact: NKDA	11/04/16 - 2201
Food Allergies-Intol: NKFA	11/04/16 - 2201
Latex Allergy (Y/N): N	11/04/16 - 2201

Pharmacy Allergy List (Coded Allergies), historical data:
(Duplicate names represent coding within (3) categories:
Ingredient, Generic and Class allergy codes.)

11/06/16

NO KNOWN DRUG ALLERGIES, NO KNOWN FOOD ALLERGIES, NO KNOWN LATEX ALLERGY

HENDERSON [REDACTED] L
10/01/13 4Y 02M
Haynes, Andrew T M.
K20034364339

12/06/17

Interdisciplinary Allergy Source Document is a Permanent Part of
the Patient's Medical Record

Willis Knighton South and Center for Womens Health

Willis Knighton South
2510 Bert Kouns Industrial Loop
Shreveport, LA 71118
318-212-5500

MEDHOST

Discharge Instructions for: [REDACTED] L

Arrival Date: 12/06/2017 08:03

Care Complete Time: 12/06/2017 09:43

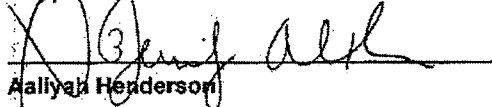
Thank you for choosing **Willis Knighton South** for your care today. The examination and treatment you have received in the Emergency Department today have been rendered on an emergency basis only and are not intended to be a substitute for an effort to provide complete medical care. You should contact your follow-up physician as it is important that you let him or her check you and report any new or remaining problems since it is impossible to recognize and treat all elements of an injury or illness in a single emergency care center visit.

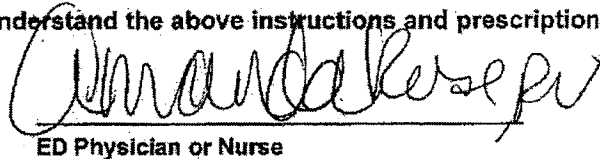
Care provided by: Haynes, Andrew, MD

Diagnosis: URI, Asthma

DISCHARGE INSTRUCTIONS	FORMS
Upper Respiratory Infection, Pediatric	None
FOLLOW UP INSTRUCTIONS	PRESCRIPTIONS
Private Physician When: 2 days	Albuterol Sulfate prednisolone
SPECIAL NOTES	
None	

I hereby acknowledge that I have received and understand the above instructions and prescriptions (if any):


Aaliyah Henderson
MRN # 1116206


ED Physician or Nurse

X-RAYS and LAB TESTS:

If you had x-rays today they were read by the emergency physician. Your x-rays will also be read by a radiologist within 24 hours. If you had a culture done it will take 24 to 72 hours to get the results. If there is a change in the x-ray diagnosis or a positive culture, we will contact you. Please verify your current phone number prior to discharge at the check out desk.

MEDICATIONS:

If you received a prescription for medication(s) today, it is important that when you fill this you let the pharmacist know all the other medications that you are on and any allergies you might have. It is also important that you notify your follow-up physician of all your medications including the prescriptions you may receive today.

Chart Copy



10/01/13 4Y 02M L
Haynes, Andrew T M.
K20034364339 12/06/17

FOLLOW UP INSTRUCTIONS

Private Physician
When: 2 days

PRESCRIPTIONS

Albuterol Sulfate 2.5 mg /3 mL (0.083 %) Inhalation Solution for Nebulization
inhale 1 unit by NEBULIZATION route every 8 hours As needed; Quantity: 1 box

Printed

prednisolone 15 mg/5 mL Oral Solution

Printed

Take 10 milliliter by ORAL route once daily for 5 days with food; Quantity: 55 milliliter

TESTS AND PROCEDURES

Labs

None

Rad

Chest Xray Portable 1 View

Procedures

Pulse Ox Continuous

Other

Call X-Ray Tech



10/01/13 4Y 02M L
Haynes, Andrew T M.
K20034364339 12/06/17



ASSIGNMENT OF BENEFITS

1. Hospital Care Consent: I/we consent to hospital services, treatment and diagnostic procedures by the hospital as may be deemed necessary or advisable by my physician and/or consultants selected by my physician. The consent to hospital care includes permission for x-ray examinations, laboratory procedures, I.V. treatments, hepatitis test administration of blood and blood products, injections, medications, recording, filming or video monitoring for internal purposes only, and hospital services rendered the patient under the general and special instruction of doctors. The patient acknowledges responsibility for any or all of these procedures. It is the hospital policy that the patient has the opportunity to discuss surgery and procedures with the patient's doctor before hand. The patient has the right to consent to surgery and procedures. Except in emergencies or unusual circumstances, the hospital does not allow its facilities to be used without this discussion and patient's consent. I voluntarily give my consent to hospital care and accept the condition of hospitalization listed.

2. Authorizations for Release of Information: The employees and agents of this hospital and copy services and electronic claims processing services under contract with this hospital and any third party billing agents for this hospital or any of its staff physicians involved with patient care are given permission to release any and all information relating to the patient, including but not limited to the medical record of the patient's hospitalization, to another healthcare provider if the patient was transferred to that facility from this hospital and to any and all insurance companies or other third-party paying or obligated to pay, in whole or in part, the charges incurred by the patient in this hospital; and they are also given permission to release the above described information to any agent or firm working for or with the above described insurance companies or other third-party payors for the purpose of performing pre-certification, concurrent and/or retrospective review and/or other utilization review of any kind.

3. Valuables: I understand and acknowledge that the hospital assumes no responsibility for personal possessions including cash, jewelry, bridgework, eyeglasses or any other personal possession which I choose to keep in my room. I have been advised that such valuables should be placed in the care of my family or deposited in the hospital vault located in the Business Office.

4. Safety Code for Hospital: Safety Codes for hospitals issued by the National Fire Protection Association prevent the use in the hospital of any electrical equipment or accessories until they have been safety checked by the hospital's electrical engineer. Exceptions to this rule are hair and blow dryers, curling irons, hot rollers, radios, clocks, electric razors, shavers, contact lens sterilizers, electric toothbrushes and calculators.

5. Payment Guaranty and Assignment of Insurance Benefits: I, the undersigned patient, guardian, and/or guarantor (hereinafter "Debtor") hereby promise to pay in full Willis-Knighton Health System (WKHS) customary charges for the goods and services rendered to the patient identified on the reverse side hereof during this period of hospitalization (hereinafter "Indebtedness"). Debtor acknowledges and agrees that, unless waived in full by WKHS as set forth below, the Indebtedness accruing during this hospitalization is due and payable in such amounts and at such times during this hospitalization as WKHS may, in its sole discretion, determine, that the entire Indebtedness is due and payable in full at discharge. I acknowledge that, upon proof of acceptable insurance coverage, WKHS, in its sole discretion, may reduce the amount of indebtedness due and payable during this hospitalizations and the balance due at discharge. In such event, I understand that all deductibles, co-insurance, non-covered charges and other items not paid by insurance or other third-party payors shall be due and payable during this period of hospitalization and upon discharge as set forth hereinabove. I acknowledge and agree that in the event that WKHS, in its sole discretion, accepts proof of insurance coverage, claims for payment for benefits will be filed on behalf of the Debtor and/or the insured and that these benefits will be considered by WKHS in determining the amounts due as set forth hereinabove. I understand and agree that WKHS will accept payments from third-party payors and insurers on behalf of the Debtor and apply such payment to the indebtedness to the extent that they are received. I acknowledge and agree that the filing of such insurance and other third-party claims is performed as a service by WKHS and in no way relieves me of the obligation to pay the Indebtedness as agreed herein above.

Patient hereby appoints WKMC as Patient's authorized representative to file any necessary claim appeal(s) on Patient's behalf. In consideration for this appointment, WKMC agrees only to collect only applicable copayments, deductibles, and coinsurance for covered benefits from the Patient and waives any right to collect any other payments related to those covered benefits from the Patient.

Debtor hereby absolutely assigns to WKHS all insurance benefits on all policies of insurance under which Debtor is an insured, whether hospital, medical, liability or other insurance, and also hereby absolutely assigns to WKHS the proceeds of any judgment or settlement of any claim against any third party and any and all other amounts which may be determined in any manner to be payable to Debtor in connection with any injury suffered by the patient which gives rise to the Indebtedness incurred during this period of treatment. I hereby authorize WKHS to obtain any and all information related to such injuries, including, but not limited to, accident reports and agree to cooperate with WKHS in connection with the procurement of any information or documents WKHS deems in its sole discretion, necessary or appropriate in connection with the assignment made pursuant to this paragraph. I hereby authorize and direct that all such payments and proceeds shall be made directly to WKHS under the terms of this assignment. Any receipts from WKHS shall be applied towards Indebtedness but such application shall not relieve the Debtor from the Debtor's obligation to pay any remaining portion to the Indebtedness. Debtor acknowledges and agrees that, to the extent that the Indebtedness has not been satisfied by such receipts, that portion of the Indebtedness for which payment has been deferred pursuant to the preceding paragraph shall be due and payable in full on the thirtieth day following the date of service. In the event that WKHS receives proceeds and/or payments in excess of the Indebtedness, WKHS may apply such excess payment to any outstanding Indebtedness of Debtor to WKHS arising out of any other period(s) of treatment as well as any attorneys' fees and expenses for which Debtor may be liable hereunder. In the event that all Indebtedness has been paid

Admission Date: 12/06/17

Admission Time: 0803



AM0005



10/01/13 4Y F
Haynes, Andrew T.M.D.
K20034364339 12/06/17



ASSIGNMENT OF BENEFITS

in full, then WKHS will refund the Debtor any such excess payment. Notwithstanding anything herein to the contrary, the assignments made hereby shall remain in full force and effect until the entire Indebtedness and any and all attorneys' fees and expenses for which Debtor may be liable have been paid in full. In the event that the Indebtedness is not paid when and as due as determined by WKHS hereunder, and the Indebtedness is placed in the hands of an attorney for purposes of collection, Debtor agrees to pay reasonable attorneys' fees, which are hereby acknowledged to be one-third (1/3) of the amount of the Indebtedness at the time the matter is placed in the hands of an attorney, plus any and all court costs and other expenses incurred in connection with the collection of the Indebtedness.

Financial assistance is available to all patients who meet the requirements of our charity care policy. Patients are encouraged to contact the Business Office if they have any concerns or need assistance in paying their bills. Our charity care policy is limited to hospital charges and does not include physician, anesthesiologist or professional charges that are not billed by the hospital. In addition, financial assistance is not offered for cosmetic, elective, experimental or other treatments and all hospital services must be ordered by your physician.

6. Assignment to Physicians: I understand that my physician as well as other physicians who treat me or otherwise involved in my care while a patient at the hospital are not employees or agents of the hospital and the hospital is not responsible for their actions. I further understand that my physician or other physicians will send me a separate bill for their services, in addition to the hospital bill. I hereby assign to all physicians who treat me the benefits due to me for these services covering medical and/or surgical expenses. I agree that should be the amount be insufficient to cover the entire medical/surgical expense, I will be responsible to said physicians for payment of the entire bill.

7. Medicare Consent: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act (SSA) is correct. I authorize Willis-Knighton Health System (WKHS) to provide (SSA) or its intermediaries with access to my medical/hospital record for the purpose of processing the Medicare claim for this or a related Medicare claim. I further request that WKHS provide such copies thereof as may be requested. Copies may be made by WKHS or its agents or contractors providing copy service and electronic claims processing services and said third party billing agents for hospital and staff physicians involved with patient care.

8. Champus/Medicare Notice: Champus/Medicare will not pay for private rooms unless medical justified, personal convenience items, diagnostic admissions or test or hospital stays not medically necessary. My signature below acknowledges my receipt of this information regarding Champus/Medicare from the hospital on the date indicated.

9. Willis-Knighton Health System (and our Medical Staff) will use and disclose your personal health information to treat you, to receive payment for the care we provide and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website and have copies available for distribution. I acknowledge that I have received a copy of the Notice of Privacy Practices.

This form has been fully explained to me. My signature reflects my understanding of the information contained herein. I further understand and acknowledge that all references to myself as the patient shall be deemed to apply as if rewritten in their entirety to a dependent for whom I am responsible for and/or who is unable to consent on their behalf for reasons indicated below.

I acknowledge that I have been informed of my rights and obligations as a patient.

Signature of Patient/Guardian	Guarantor	Witness
12/06/17	12/06/17	12/06/17
Date/Time	Date/Time	Date/Time
Print Name	Print Name	Print Name

If Patient/Guarantor is unable to sign, I, _____, do hereby state that I have been given the authority to sign for

_____, either expressed or implied and that he or she is fully aware of this authority.

Signature of
Authorized Party

Authorized Party's
Relationship to the Patient

Date/Time

Witness

Date/Time

Admission Date: 12/06/17
Admission Time: 0803



AM0005



L
10/01/13 4Y F
Haynes, Andrew T M.D.
K20034364339 12/06/17

WILLIS-KNIGHTON MEDICAL CENTER
SHREVEPORT, LA
EMERGENCY ROOM REGISTRATION INFORMATION (3008)

NAME: [REDACTED] L

ACCT. NO: K20034257293

GUARANTOR: ALEXANDER, JENNIFER

NEXT OF KIN: ALEXANDER, JENNIFER

ADDRESS: 2247 LEGARDY STREET
SHREVEPORT, LA 71107ADDRESS: 2247 LEGARDY STREET
SHREVEPORT, LA 71107

PHONE: (318)210-3821

PHONE: (318)210-3821

RELATION: PARENT

GUAR EMPLOYER: CHILD

ADDRESS:

ARRIVED FROM: C

ATTENDING PHYS: Willis Jr, Fred Spence M.D.

PHONE:

ADMIT/OTHER PHYS:

PRIM CARE PHYS:

	NAME	POLICY #	GROUP #	BENEFIT PLAN
PRIMARY INS:	LA HLTHCARE CONN LA ME	1997286459512	[REDACTED] L	MEDICAID
SECONDARY INS:				
TERTIARY INS:				
FOURTH INS:				

ACCT NO: K20034257293

DATE: 11/04/17

UNIT#: K000629604

ROOM:

TIME: 1636

F/C: MA

STATUS: REG ER

SERV/LOC: ERS

SS#: 338-89-3614

PATIENT: [REDACTED] L

BIRTHDATE: 10/01/13

ADDRESS: 2247 LEGARDY STREET
SHREVEPORT, LA 71107

AGE: 4Y

SEX: F

PHONE: (318)210-3821

RACE: BLACK OR AFRICAN AME

RELIGION: Other

COUNTY: CADD O PARISH

MARITAL STAT: SINGLE

EMPLOYER: GOD'S GIFT

PERSON TO NOTIFY: ALEXANDER, JENNIFER

ADDRESS: 2305 MARIAN PL
SHREVEPORT, LA 71109ADDRESS: 2247 LEGARDY STREET
SHREVEPORT, LA 71107

000-0000

PHONE: (318)210-3821

RELATION: PARENT

Is the Patient here for Pre-Op Testing: N

Comments:

Admit Clerk: SAFFED2.A

Reason for Visit: COUGH, RUNNY NOSE

Baby ID#:

Known Drug Allergies: A

HIPPA Notice Given: Y

Date Notice Given: 09/23/14

Device Id: AMSPC5

Interpreter ID Number:

Patient Survey: U

Preferred Language: ENGLISH

Ethnicity: NHILAT

Do you have an advanced directive that you would like to present to us today? U



K20034257293

Physician Documentation

Willis Knighton South

Name: Aaliyah [REDACTED]
Age: 4 yrs Sex: Female DOB: 10/01/2013
Arrival Date: 11/04/2017 Time: 16:36
Bed Post IM1

MRN: 1116206
Account#: K20034257293
Private MD: LSU/UH, Medical Clinic

HPI:

11/04 This 4 yrs old Black/African Am Female presents to ED via Ambulatory with complaints of **Cough, Runny** sw2/klb2
17:26 **Nose**

17:26 The patient presents to the emergency department with congestion, cough, fever. Onset: The sw2/klb2
symptoms/episode began/occurred 2 day(s) ago. Associated signs and symptoms: Pertinent positives:
congestion, cough, fever, Pertinent negatives: abdominal pain, constipation, diarrhea, headache, seizure,
sore throat, vomiting, wheezing. Modifying factors: The patient symptoms are alleviated by nothing, the
patient symptoms are aggravated by nothing. It is unknown whether or not the patient has had similar
symptoms in the past. It is unknown whether or not the patient has recently seen a physician.

Historical:

- **Allergies:** Codeine; SEA FOOD; FISH PRODUCT DERIVATIVES (Hives);

- **Home Meds:**

1. Dulera 100-5 mcg/actuation inhalation [REDACTED] 2 puffs 2 times per day
2. Singulair 5 mg oral chew once daily
3. Albuterol Inhl as needed

- **PMHx:** Asthma; Autism

- **PSHx:** None

Historical:

16:51 Family history: Pertinent for; recent upper respiratory infection symptoms, similar symptoms recently, No hp1
immediate family members are acutely ill. Immunization history: Childhood immunizations up to date,
Last flu immunization: up to date. Social history: The patient lives at home with family the patient is a
minor.

17:26 The history from nurses notes was reviewed and confirmed. sw2/klb2

ROS:

17:26 **Constitutional:** Positive for coughing, fever, Negative for chills, fatigue, fussiness, obvious distress, poor sw2/klb2
PO intake, vomiting. **ENT:** Positive for sinus congestion, Negative for difficulty swallowing, nose bleed,
sore throat. **Respiratory:** Positive for cough, Negative for hemoptysis, pleurisy, sputum production,
wheezing,

17:44 ROS as in the HPI, and all other systems were reviewed negative, or noncontributory, except as sw2/klb2
mentioned below. **Eyes:** r **Neck:** Negative for injury, pain, and swelling, **Cardiovascular:** Negative for
chest pain, palpitations, and edema, **Abdomen/GI:** Negative for abdominal pain, nausea, vomiting,
diarrhea, and constipation, **Back:** Negative for injury and pain, **GU:** Negative for injury, bleeding,
discharge, and swelling, **MS/Extremity:** Negative for injury and deformity, **Skin:** Negative for injury, rash,
and discoloration, **Neuro:** Negative for headache, weakness, numbness, tingling, and seizure.

Exam:

17:44 sw2/klb2

Head/Face: Normocephalic, atraumatic.

Eyes: PERRLA, EOMI. Normal conjunctiva with no evidence of injection or discharge. Sclera are non-
icteric. No gross corneal defects and anterior chambers appear normal by gross inspection.

Neck: Supple. Trachea midline. No lymphadenopathy or masses. Normal ROM with no evidence of
vertebral point tenderness. No meningismus. Lymphatic No abnormal lymphadenopathy noted by
palpation in the neck or axilla

Chest/axilla: Normal symmetrical motion. No tenderness. No crepitus. No axillary masses or tenderness.

Cardiovascular: Regular rate and rhythm with normal S1 and S2. no murmurs, rubs or gallops. Pulses
intact and symmetrical throughout. No edema or JVD.

Respiratory: CTA with excellent breath sounds in all fields. Symmetrical chest wall movement with no
wheezing, rales, or rhonchi. No evidence of stridor or nasal flaring.

Physician Documentation Con't.

Abdomen/GI: Soft, non-tender with normal bowel sounds. No distension, tympany or bruits. No guarding, rebound or rigidity. No palpable masses or evidence of tenderness with thorough palpation.

Back: Normal inspection with no obvious deformity. No spinal or CVA tenderness. Normal ROM without pain

Skin: Warm and dry with excellent turgor. capillary refill <2 seconds. No cyanosis, pallor, rash or edema.

MS/ Extremity: No evidence of focal tenderness or deformity. Full ROM throughout with no evidence of weakness.

Neuro: Awake, alert, with age appropriate mental status. CN 2-12 grossly intact. Motor strength 5/5 throughout with sensory grossly intact. Age appropriate cerebellar function. Age appropriate ambulatory ability.

Constitutional: The patient appears Blood pressure, pulse, respirations and temperature noted. awake, alert, well developed, well groomed, well nourished, pleasant, non-toxic, afebrile.

ENT: TM's: bulging, is not appreciated, dullness, on the right, erythema, that is moderate, on the right, Nose: is normal, no abrasion, no bleeding, no clotted blood, no edema, no erythema, no laceration, Posterior pharynx: is normal, airway is patent, no erythema, no exudate, no peritonsillar mass.

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Pain	Staff
16:38	106 / 74	122	22	98.9(T)	99% on R/A	17.24 kg / 38 lbs 0 oz		kw1

Glasgow Coma Score:

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
16:38	spontaneous(4)	oriented(5)	obeys commands(6)		15	kw1

MDM:

17:40 Patient medically screened.

sw2

17:56

sw2

Differential diagnosis: bacterial infection, bronchitis, fever, gastroenteritis, meningitis, pneumonia URI, UTI, viral infection.

Data reviewed: vital signs, nurses notes, and as a result, I will continue to observe the patient.

Data interpreted: Pulse oximetry: normal.

Counseling: I had a detailed discussion with the patient and/or guardian regarding: the historical points, exam findings, and any diagnostic results supporting the discharge/admit diagnosis, the need for outpatient follow up, to return to the emergency department if symptoms worsen or persist or if there are any questions or concerns that arise at home. Evaluation of the patients emergency department complaint with medical screening exam, it has been determined no emergency medical condition exists.

Response to treatment: the patient's symptoms have markedly improved after treatment.

Order	Status	Time	By	For
Chest 2 View *routine*	Ordered	11/04/17 17:14	sw2	sw2
	Canceled	11/04/17 18:08	Dispatcher MedHost	
Notes: Bed Name: 14:	Order Method: Electronic			
Interpretation: NEGATIVE ACUTE.				
Is the patient able to bear weight? (OERDBEARWT):				
Is the patient at risk for falls? (OERDFALLS):				
MODE OF TRANSPORTATION : (OERDTRANS): Stretcher				
O2: (OEADO2): No				
Priority RAD: Stat				

Name: Aaliyah [REDACTED]

MRN: 1116206

Account#: K20034257293

Print Time: 11/5/2017 20:27:40

Page 2 of 4

Physician Documentation Con't.

REASON FOR EXAM: (OERDEXAM): Cough, Runny Nose				
WEIGHT?: (OERDWEIGHT): 17.24				
ER EXAM ROOM/BED: (OERDERRMBD): 14				
Order	Status	Time	By	For
Call X-Ray Tech	Ordered	11/04/17 17:14	sw2	sw2
	Completed	11/04/17 17:18	Steven Clinger	
Notes:	Order Method: Electronic			
Order	Status	Time	By	For
Rocephin 500 mg with Lidocaine 1% as diluent - (Rocephin 500 mg, Lidocaine 1 mL) IM once	Ordered	11/04/17 18:03	sw2	sw2
	Administered	11/04/17 18:31	sh1	
Notes:	Order Method: Electronic			
11/04/17 18:31	Administered: Rocephin 500 mg with Lidocaine 1% as diluent - (Rocephin 500 mg, Lidocaine 1 mL) IM in left ventrogluteal			sh1
11/04/17 19:01	Follow Up: Response: No Adverse Reaction			sh1
11/04/17 19:10	Follow Up: Response: No Adverse Reaction			kb7
Order	Status	Time	By	For
XR, chest 1 view portable	Ordered	11/04/17 18:08	EDMS	
	Reviewed	11/04/17 18:18	Fred Willis	
Notes:	Order Method:			
	Sign off:			
Interpretation: No acute disease except: possible infiltrate.				

Order Signatures:

Willis, Fred, MD

MD sw2

Dispatcher MedHost

EDMS

Scribe Statement:

11/04

17:26 Scribed for **Dr. Fred S Willis, Jr, MD** by Kerri L Barlow, Scribe

sw2/klb2

Disposition:

17:56 Electronically signed by: FRED WILLIS JR MD. I personally performed the services described in this documentation as scribed in my presence and it is both accurate and complete. Disposition. Chart complete.

sw2

Disposition:**11/04/17 18:00 Discharged to Home/Self Care. Impression: ACUTE BRONCHITIS.**

- Condition is Stable.
- Discharge Instructions: Acute Bronchitis, Easy-to-Read.
- Prescriptions for
 - Amoxicillin 400 mg/5 mL Oral Suspension for Reconstitution
 - take 10.1 milliliter by ORAL route every 12 hours for 10 days MAX dose = 1750mg/day; 200 milliliter.
 - Guaifenesin
 - DM 10-100 mg/5 mL Oral Liquid - take 5 milliliter by ORAL route every 8 hours As needed as needed; 60 milliliter.
- Follow up: Willis-Knighton, Tots to Teens Clinic; When: Tomorrow.

Name: Aaliyah [REDACTED]

MRN: 1116206

Account#: K20034257293

Print Time: 11/5/2017 20:27:40

Page 3 of 4

Physician Documentation Con't.

- Problem is new.
- Symptoms have improved.

Signatures:

Dispatcher MedHost	EDMS	Clinger, Steven, RN	RN	smc	
Hovingh, Sue, RN	RN	sh1	Walthall, Kimberlene, RN	RN	kw1
Willis, Fred, MD	MD	sw2	Barlow, Kerri, Scribe	Scribe	klb2
Pitarro, Holly, RN	RN	hp1	Breaux, Kristie, RN	RN	kb7

Corrections:

17:44 17:26 Respiratory: Positive for cough, Negative for hemoptysis, pleurisy, sputum production, wheezing.	sw2/klb2	sw2/klb2
18:08 17:14 XR, chest 2 view + XR ordered.	EDMS	EDMS
18:08 18:03 XR, chest 2 view + XR reviewed.	sw2	EDMS
18:08 18:03 NEGATIVE ACUTE.	sw2	EDMS
18:18 18:18 possible infiltrate.	sw2	sw2

Name: Aaliyah [REDACTED]

Print Time: 11/5/2017 20:27:40

MRN: 1116206
Account#: K20034257293
Page 4 of 4

Nurse's Notes

Name: Aaliyah [REDACTED]
Age: 4 yrs **Sex:** Female **DOB:** 10/01/2013
Arrival Date: 11/04/2017 **Time:** 16:36

Willis Knighton South

MRN: 1116206
Account#: K20034257293
Private MD: LSU/UH, Medical Clinic

Bed Post IM1**Presentation:**

11/04 [REDACTED] kw1
 16:38 Method of Arrival: Ambulatory.
 16:38 Preferred language for medical communication is English. Presenting complaint: Patient states: patient to er kw1
 with complaints of having cough congestion fever and runny nose for the past 3 days. Person Transporting:
 Parent. Transition of care: patient was not received from another setting of care.
 16:41 Acuity: 4 - Semi-Urgent. kw1

Triage Assessment:

16:38 **General:** Appears well developed, well nourished, well groomed; Behavior is cooperative, pleasant. **Pain:** kw1
 Faces, Legs, Activity, Cry, Consolability scale score is 0 out of 10.

Historical:

- **Allergies:** Codeine; SEA FOOD; FISH PRODUCT DERIVATIVES (Hives);
- **Home Meds:**
 1. Dulera 100-5 mcg/actuation inhalation [REDACTED] 2 puffs 2 times per day
 2. Singulair 5 mg oral chew once daily
 3. Albuterol Inhaler as needed
- **PMHx:** Asthma; Autism
- **PSHx:** None

Historical:

16:51 Family history: Pertinent for; recent hp1
 upper respiratory infection symptoms, similar symptoms recently, No immediate family members are acutely ill. Immunization history: Childhood immunizations up to date, Last flu immunization: up to date. Social history: The patient lives at home with family the patient is a minor.
 17:26 The history from nurses notes was sw2/klb2 reviewed and confirmed.

Screening:

16:38 **Abuse screen:** kw1
 Denies threats or abuse.
Patient fall risk assessment:
 risks identified; None.
Learning Barriers:
 age barrier identified, caregiver ready and willing to learn, prefers oral and written instructions.
Pedi Fall Risk
 None Identified.
Exposure risk/Travel Screening:
 None identified.

Assessment:

16:51 **Pain:** Denies pain. level that is acceptable is 0 out of 10 on a pain scale. **General:** Appears in no apparent hp1
 distress, well developed, well nourished, well groomed, Behavior is appropriate for age, playing, mobility; ambulates without assistance Reports fever for 0-12 hours, feeling ill for 0-12 hours. **Neuro:** Level of Consciousness is alert, awake, obeys commands, appropriate to pain. Oriented to person, Moves all extremities. **EENT:** Parent/caregiver reports the patient having nasal discharge that is watery pulling at both ears. **Cardiovascular:** Heart tones S1 S2. **Respiratory:** Respiratory effort is even, unlabored, Respiratory pattern is regular, symmetrical, Airway is patent Breath sounds are clear bilaterally. Reports cough that is non-productive. **Dermatologic:** Skin is intact, is healthy with good turgor, Skin is dry, Skin is normal, Skin temperature is warm. **Musculoskeletal:** No deficits noted.

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Pain	Staff
16:38	106 / 74	122	22	98.9(T)	99% on R/A	17.24 kg / 38 lbs 0 oz		kw1

Vitals:

Nurse's Notes Con't

16:38 Acuity: 4 - Semi-Urgent.

kw1

Glasgow Coma Score:

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
16:38	spontaneous(4)	oriented(5)	obeys commands(6)		15	kw1

ED Course:

16:36 Patient arrived in ED. ms2
 16:36 Patient moved to KIOSK. ms2
 16:38 LSU/UH, Medical Clinic is Private Physician. kw1
 16:41 Triage completed. kw1
 16:41 Patient moved to Waiting. kw1
 16:45 Patient moved to 14. hp1
 16:47 Hovingh, Sue, RN is Primary Nurse. sh1
 16:50 No procedures done that require assistance. hp1
 16:50 Patient/caregiver encouraged to voice any concerns. Side rails up X 1. Bed in low position. Call light in reach. Patient has correct armband on for positive identification. Adult with patient. hp1
 17:14 Willis, Fred, MD is Attending Physician. sw2
 17:20 No apparent distress. Resting quietly. sh1
 17:48 Patient moved to Radiology. jsr
 17:48 Patient moved to 14. jsr
 17:50 No apparent distress. Resting quietly. sh1
 17:57 Willis-Knighton, Tots to Teens Clinic is Referral Physician. sw2
 18:20 No apparent distress. Resting quietly. sh1
 18:50 No apparent distress. Resting quietly. sh1
 19:10 Patient moved to Post IM1. cb6

Administered Medications:

Time	Drug & Dose Dispensable & Quantity	Volume	Route	Rate	Infused Over	Site	Delivery	Staff
18:31	Rocephin 500 mg with Lidocaine 1% as diluent - (Rocephin 500 mg, Lidocaine 1 mL)		IM			left ventrogluteal		sh1
19:01	Follow up: Response: No Adverse Reaction							sh1
19:10	Follow up: Response: No Adverse Reaction							kb7

Outcome:

18:00 Discharge ordered by MD. sw2
 19:10 Discharged to home, ambulatory, with family. Discharge instructions given to family, Instructed on discharge instructions, follow up and referral plans, medication usage, Demonstrated understanding of instructions, medications, Prescriptions given; 2, No questions or concerns expressed to me at discharge. No belongings were removed by WK staff. **Medication reconciliation form provided. Med Effects:** Effects of administered medications were addressed. **Oxygen use:** Oxygen use not applicable. kb7
 19:11 Electronic medical record closed. kb7

Name: Aaliyah [REDACTED]

MRN: 1116206

Account#: K20034257293

Print Time: 11/5/2017 20:27:39

Page 2 of 3

Nurse's Notes Con't

Signatures:

Hovingh, Sue, RN	RN sh1	Walthall, Kimberlene, RN	RN kw1
Rivers, Jaime, RT	RT jsr	Willis, Fred, MD	MD sw2
Scriptuser, MEDHOST	ms2	Barlow, Kerri, Scribe	Scribe klb2
Pitarro, Holly, RN	RN hp1	Blackmon, Connor, ED Tech	ED Tech cb6
Breaux, Kristie, RN	RN kb7		

Corrections:

18:08 17:48 To radiology for XR, chest 2 view + XR.

jsr EDMS

Pt Name: [REDACTED] L
 Pt ID: 0101757329
 DOB: 10/01/2013
 Adm DTime: 11/04/2017
 Dsch DTime: 11/04/2017
 Entity: Willis-Knighton South
 Dx:

MRN: 1116206
 Acct No: K20034257293
 Age/Sex: 4Y/F
 Atn Dr: Willis, Fred MD

Order #: 4374088
 Order Type/Sub Type: Radiology/XRay
 Order As Written: XR, chest 1 view portable Reason Cough, Runny Nose STAT

Order History

Order Source:
 Ordered By: Fred Spencer Willis, MD
 Entered By: JRS on 11/4/2017 6:07:00PM
 Order Entered by RAD on 11/04/2017 18:09
 In progress by RAD on 11/04/2017 18:09
 Discontinue by HSF_JS on 11/04/2017 23:01
 Reason for Revision: Visit is closed for the patient
 Electronically Signed By:

Pt. Name: [REDACTED] L
 Entity: Willis-Knighton South
 Adm Date: 11/04/2017

MRN: 1116206
 Page 1 of 1

CPOE Orders Report
 ORE W0TB 0149 CPOE Report V9 1.rpt.
 Generated By: Workflow
 Generated On: 05-Nov-17 19:15

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Willis-Knighton South
2510 Bert Kouns Industrial Loop
Shreveport, LA 71118

Patient Name: [REDACTED]
Adm No: K20034257293
DOB: 10/01/2013
Age: 4Y F
Corp ID: 000001116206

MRN: 1116206
Location: ER Patient - -
Ord No: 90020
Hospital: WKS

Ordering Dr: FRED SPENCER WILLIS JR

CC:

Final Report

Admitting Diagnosis: COUGH,RUNNY NOSE
Reason For Exam: Cough, Runny Nose
Procedure Date: 11/04/2017
Procedure: SXR - XR, chest 1 view portable

Interpretive Location: BOS
Accession Number: 3843553
CPT Code: 71010

IMPRESSION: Normal portable chest.

RESULT:

Procedure: XR, chest 1 view portable

Clinical Information: Cough, Runny Nose

Comparison: 9/23/2017.

Findings:

Heart size and contour are normal for portable technique. The lungs are clear of infiltrate, mass, or effusion. No significant skeletal abnormality is noted.

Electronically Signed by: CORNELIUS J BOS M.D. on Nov 5 2017 5:37A

Techs: Jaime S Rivers Melinda H Durr
Additional Staff:

Read by: CORNELIUS J BOS M.D. on Nov 5 2017 5:37A
Electronically Signed by: CORNELIUS J BOS M.D. on Nov 5 2017 5:37A

Printed: Nov 5 2017 5:41AM

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ALLERGY REPORT

Pt Name: [REDACTED] L MRN: 1116206
Pt ID: 0101757329 Acct No: K20034257293
DOB: 10/01/2013 Age/Sex: 4Y/F
Adm DTime: 11/04/2017 16:36 Atn Dr: Willis, Fred MD
Nurs Sta: Willis-Knighton South Rm & Bed:
Dx:
Alerg: codeine, Fish Containing Products, Fish containing products

Alerg Type	Alerg Name	Onset	Reaction	Severity	Comment
Drug	codeine	7/14/2017	Shortness of Breath	Severe	"Took codeine yesterday. Started wheezing, couldnt breathe like she was having an asthma attack"
Drug	Fish Containing Products	05/2017	Anaphylaxis	Severe	Patient severely allergic. Reaction when touches seafood
Food	Fish containing products	05/2017	Anaphylaxis	Severe	Patient severely allergic. Reaction when touches seafood

Pt Name: [REDACTED] L
Rm/ Bed:

MRN: 1116206
Page 1 of 1

RUN DATE: 11/04/17
RUN TIME: 1642
RUN USER: SAFPED2.AM

Willis Knighton *ADMISSION
INTERDISCIPLINARY ALLERGY SOURCE DOCUMENT

PAGE 1

Name: [REDACTED] L DOB: 10/01/13 Age: 4Y 01M
Rm/Bd: Serv/Locn: ERS Status: ER Sex: F
Unit#: K000629604 Account#: K20034257293 EPI#: 000000001116206

Last Update/
Acknowledgement:

Interdisciplinary Assessment (Free Text), historical data:

Allergy1-Med/Contact: NKDA	11/04/16 - 2201
Allergy2-Med/Contact: NKDA	11/04/16 - 2201
Food Allergies-Intol: NKFA	11/04/16 - 2201
Latex Allergy (Y/N): N	11/04/16 - 2201

Pharmacy Allergy List (Coded Allergies), historical data:
(Duplicate names represent coding within (3) categories:
Ingredient, Generic and Class allergy codes.)

11/06/16

NO KNOWN DRUG ALLERGIES, NO KNOWN FOOD ALLERGIES, NO KNOWN LATEX ALLERGY

Interdisciplinary Allergy Source Document is a Permanent Part of
the Patient's Medical Record



ALIYAH L
10/01/13 4Y 01M
Willis Jr, Fred Spe
K20034257293 11/04/17

Willis Knighton South and Center for Womens Health

Willis Knighton South
2510 Bert Kouns Industrial Loop
Shreveport, LA 71118
318-212-5500

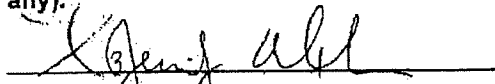
**Discharge Instructions for:** [REDACTED]**Arrival Date:** 11/04/2017 16:36**Care Complete Time:** 11/04/2017 18:00

Thank you for choosing **Willis Knighton South** for your care today. The examination and treatment you have received in the Emergency Department today have been rendered on an emergency basis only and are not intended to be a substitute for an effort to provide complete medical care. You should contact your follow-up physician as it is important that you let him or her check you and report any new or remaining problems since it is impossible to recognize and treat all elements of an injury or illness in a single emergency care center visit.

Care provided by: Willis, Fred, MD**Diagnosis:** ACUTE BRONCHITIS

DISCHARGE INSTRUCTIONS	FORMS
Acute Bronchitis, Easy-to-Read	None
FOLLOW UP INSTRUCTIONS	PRESCRIPTIONS
Willis-Knighton, Tots to Teens Clinic When: Tomorrow	Amoxicillin Guaifenesin-DM
SPECIAL NOTES	
None	

I hereby acknowledge that I have received and understand the above instructions and prescriptions (if any).


Aaliyah Henderson

MRN # 1116206


ED Physician or Nurse


X-RAYS and LAB TESTS:

If you had x-rays today they were read by the emergency physician. Your x-rays will also be read by a radiologist within 24 hours. If you had a culture done it will take 24 to 72 hours to get the results. If there is a change in the x-ray diagnosis or a positive culture, we will contact you. Please verify your current phone number prior to discharge at the check out desk.

MEDICATIONS:

If you received a prescription for medication(s) today, it is important that when you fill this you let the pharmacist know all the other medications that you are on and any allergies you might have. It is also important that you notify your follow-up physician of all your medications including the prescriptions you may receive today.

Chart Copy


HENDERSON
10/01/13 4Y 01M
Willis Jr, Fred Spe
K20034257293
11/04/17

FOLLOW UP INSTRUCTIONS

Willis-Knighton, Tots to Teens Clinic (Pediatrics)
845 Olive St
Shreveport, LA 71104
318-226-4892
When: Tomorrow

PRESCRIPTIONS

Amoxicillin 400 mg/5 mL Oral Suspension for Reconstitution

Printed

Take 10.1 milliliter by ORAL route every 12 hours for 10 days MAX dose = 1750mg/day; Quantity: 200 milliliter

Gualfenesin-DM 10-100 mg/5 mL Oral Liquid

Printed

Take 5 milliliter by ORAL route every 8 hours As needed as needed; Quantity: 60 milliliter

TESTS AND PROCEDURES

Labs

None

Rad

Chest 2 View *routine*

Procedures

None

Other

Call X-Ray Tech



HENDERSON [REDACTED] L
10/01/13 4Y 01M
Willis Jr, Fred Spe
K20034257293 11/04/17



ASSIGNMENT OF BENEFITS

1. Hospital Care Consent: I/we consent to hospital services, treatment and diagnostic procedures by the hospital as may be deemed necessary or advisable by my physician and/or consultants selected by my physician. The consent to hospital care includes permission for x-ray examinations, laboratory procedures, I.V. treatments, hepatitis test administration of blood and blood products, injections, medications, recording, filming or video monitoring for internal purposes only, and hospital services rendered the patient under the general and special instruction of doctors. The patient acknowledges responsibility for any or all of these procedures. It is the hospital policy that the patient has the opportunity to discuss surgery and procedures with the patient's doctor before hand. The patient has the right to consent to surgery and procedures. Except in emergencies or unusual circumstances, the hospital does not allow its facilities to be used without this discussion and patient's consent. I voluntarily give my consent to hospital care and accept the condition of hospitalization listed.

2. Authorizations for Release of Information: The employees and agents of this hospital and copy services and electronic claims processing services under contract with this hospital and any third party billing agents for this hospital or any of its staff physicians involved with patient care are given permission to release any and all information relating to the patient, including but not limited to the medical record of the patient's hospitalization, to another healthcare provider if the patient was transferred to that facility from this hospital and to any and all insurance companies or other third-party paying or obligated to pay, in whole or in part, the charges incurred by the patient in this hospital; and they are also given permission to release the above described information to any agent or firm working for or with the above described insurance companies or other third-party payors for the purpose of performing pre-certification, concurrent and/or retrospective review and/or other utilization review of any kind.

3. Valuables: I understand and acknowledge that the hospital assumes no responsibility for personal possessions including cash, jewelry, bridgework, eyeglasses or any other personal possession which I choose to keep in my room. I have been advised that such valuables should be placed in the care of my family or deposited in the hospital vault located in the Business Office.

4. Safety Code for Hospital: Safety Codes for hospitals issued by the National Fire Protection Association prevent the use in the hospital of any electrical equipment or accessories until they have been safety checked by the hospital's electrical engineer. Exceptions to this rule are hair and blow dryers, curling irons, hot rollers, radios, clocks, electric razors, shavers, contact lens sterilizers, electric toothbrushes and calculators.

5. Payment Guaranty and Assignment of Insurance Benefits: I, the undersigned patient, guardian, and/or guarantor (hereinafter "Debtor") hereby promise to pay in full Willis-Knighton Health System (WKHS) customary charges for the goods and services rendered to the patient identified on the reverse side hereof during this period of hospitalization (hereinafter "Indebtedness"). Debtor acknowledges and agrees that, unless waived in full by WKHS as set forth below, the Indebtedness accruing during this hospitalization is due and payable in such amounts and at such times during this hospitalization as WKHS may, in its sole discretion, determine, that the entire Indebtedness is due and payable in full at discharge. I acknowledge that, upon proof of acceptable insurance coverage, WKHS, in its sole discretion, may reduce the amount of indebtedness due and payable during this hospitalizations and the balance due at discharge. In such event, I understand that all deductibles, co-insurance, non-covered charges and other items not paid by insurance or other third-party payors shall be due and payable during this period of hospitalization and upon discharge as set forth hereinabove. I acknowledge and agree that in the event that WKHS, in its sole discretion, accepts proof of insurance coverage, claims for payment for benefits will be filed on behalf of the Debtor and/or the insured and that these benefits will be considered by WKHS in determining the amounts due as set forth hereinabove. I understand and agree that WKHS will accept payments from third-party payors and insurers on behalf of the Debtor and apply such payment to the indebtedness to the extent that they are received. I acknowledge and agree that the filing of such insurance and other third-party claims is performed as a service by WKHS and in no way relieves me of the obligation to pay the Indebtedness as agreed herein above.

Patient hereby appoints WKMC as Patient's authorized representative to file any necessary claim appeal(s) on Patient's behalf. In consideration for this appointment, WKMC agrees only to collect only applicable copayments, deductibles, and coinsurance for covered benefits from the Patient and waives any right to collect any other payments related to those covered benefits from the Patient.

Debtor hereby absolutely assigns to WKHS all insurance benefits on all policies of insurance under which Debtor is an insured, whether hospital, medical, liability or other insurance, and also hereby absolutely assigns to WKHS the proceeds of any judgment or settlement of any claim against any third party and any and all other amounts which may be determined in any manner to be payable to Debtor in connection with any injury suffered by the patient which gives rise to the Indebtedness incurred during this period of treatment. I hereby authorize WKHS to obtain any and all information related to such injuries, including, but not limited to, accident reports and agree to cooperate with WKHS in connection with the procurement of any information or documents WKHS deems in its sole discretion, necessary or appropriate in connection with the assignment made pursuant to this paragraph. I hereby authorize and direct that all such payments and proceeds shall be made directly to WKHS under the terms of this assignment. Any receipts from WKHS shall be applied towards Indebtedness but such application shall not relieve the Debtor from the Debtor's obligation to pay any remaining portion to the Indebtedness. Debtor acknowledges and agrees that, to the extent that the Indebtedness has not been satisfied by such receipts, that portion of the Indebtedness for which payment has been deferred pursuant to the preceding paragraph shall be due and payable in full on the thirtieth day following the date of service. In the event that WKHS receives proceeds and/or payments in excess of the Indebtedness, WKHS may apply such excess payment to any outstanding Indebtedness of Debtor to WKHS arising out of any other period(s) of treatment as well as any attorneys' fees and expenses for which Debtor may be liable hereunder. In the event that all Indebtedness has been paid

Admission Date: 11/04/17

Admission Time: 1636



AM0005



HENDERSON L
10/01/13 4Y F
Willis Jr, Fred Spence M.D.
K20034257293 11/04/17



ASSIGNMENT OF BENEFITS

in full, then WKHS will refund the Debtor any such excess payment. Notwithstanding anything herein to the contrary, the assignments made hereby shall remain in full force and effect until the entire Indebtedness and any and all attorneys' fees and expenses for which Debtor may be liable have been paid in full. In the event that the Indebtedness is not paid when and as due as determined by WKHS hereunder, and the Indebtedness is placed in the hands of an attorney for purposes of collection, Debtor agrees to pay reasonable attorneys' fees, which are hereby acknowledged to be one-third (1/3) of the amount of the Indebtedness at the time the matter is placed in the hands of an attorney, plus any and all court costs and other expenses incurred in connection with the collection of the Indebtedness.

Financial assistance is available to all patients who meet the requirements of our charity care policy. Patients are encouraged to contact the Business Office if they have any concerns or need assistance in paying their bills. Our charity care policy is limited to hospital charges and does not include physician, anesthesiologist or professional charges that are not billed by the hospital. In addition, financial assistance is not offered for cosmetic, elective, experimental or other treatments and all hospital services must be ordered by your physician.

6. Assignment to Physicians: I understand that my physician as well as other physicians who treat me or otherwise involved in my care while a patient at the hospital are not employees or agents of the hospital and the hospital is not responsible for their actions. I further understand that my physician or other physicians will send me a separate bill for their services, in addition to the hospital bill. I hereby assign to all physicians who treat me the benefits due to me for these services covering medical and/or surgical expenses. I agree that should be the amount be insufficient to cover the entire medical/surgical expense, I will be responsible to said physicians for payment of the entire bill.

7. Medicare Consent: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act (SSA) is correct. I authorize Willis-Knighton Health System (WKHS) to provide (SSA) or its intermediaries with access to my medical/hospital record for the purpose of processing the Medicare claim for this or a related Medicare claim. I further request that WKHS provide such copies thereof as may be requested. Copies may be made by WKHS or its agents or contractors providing copy service and electronic claims processing services and said third party billing agents for hospital and staff physicians involved with patient care.

8. Champus/Medicare Notice: Champus/Medicare will not pay for private rooms unless medical justified, personal convenience items, diagnostic admissions or test or hospital stays not medically necessary. My signature below acknowledges my receipt of this information regarding Champus/Medicare from the hospital on the date indicated.

9. Willis-Knighton Health System (and our Medical Staff) will use and disclose your personal health information to treat you, to receive payment for the care we provide and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website and have copies available for distribution. I acknowledge that I have received a copy of the Notice of Privacy Practices.

This form has been fully explained to me. My signature reflects my understanding of the information contained herein. I further understand and acknowledge that all references to myself as the patient shall be deemed to apply as if rewritten in their entirety to a dependent for whom I am responsible for and/or who is unable to consent on their behalf for reasons indicated below.

I acknowledge that I have been informed of my rights and obligations as a patient.

 _____ Signature of Patient/Guardian	_____ Date/Time	 _____ Guarantor	_____ Date/Time	 _____ Witness	11/4/17 _____ Date/Time
 _____ Print Name		 _____ Print Name		 _____ Print Name	1636 _____ Date/Time

If Patient/Guarantor is unable to sign, I, _____, do hereby state that I have been given the authority to sign for

_____, either expressed or implied and that he or she is fully aware of this authority.

_____ Signature of Authorized Party	_____ Authorized Party's Relationship to the Patient	_____ Date/Time	_____ Witness	_____ Date/Time
---	--	--------------------	------------------	--------------------

Admission Date: 11/04/17
Admission Time: 1636



AM0005



10/01/13 4Y F
Willis Jr, Fred Spence M.D.
K20034257293 11/04/17

WILLIS-KNIGHTON MEDICAL CENTER
SHREVEPORT, LA
EMERGENCY ROOM REGISTRATION INFORMATION (3018)

NAME: [REDACTED] L ACCT. NO: K20034103612
GUARANTOR: ALEXANDER, JENNIFER NEXT OF KIN: ALEXANDER, JENNIFER
ADDRESS: 2247 LEGARDY STREET ADDRESS: 2247 LEGARDY STREET
SHREVEPORT, LA 71107 SHREVEPORT, LA 71107
PHONE: (318) 210-3821 PHONE: (318) 210-3821 RELATION: PARENT

GUAR EMPLOYER: CHILD
ADDRESS:

ARRIVED FROM: C
ATTENDING PHYS: Brandhurst, Roy E M.D.
ADMIT/OTHER PHYS:
PRIM CARE PHYS:

	NAME	POLICY #	GROUP #	BENEFIT PLAN
PRIMARY INS:	LA HLTHCARE CONN LA ME	1997286459512	[REDACTED]	MEDICAID
SECONDARY INS:				
TERTIARY INS:				
FOURTH INS:				

ACCT NO: K20034103612 DATE: 09/23/17 UNIT#: K000629604
ROOM: TIME: 1813 F/C: MA
STATUS: REG ER SERV/LOC: ERS SS#: 338-89-3614

PATIENT: [REDACTED] L BIRTHDATE: 10/01/13
ADDRESS: 2247 LEGARDY STREET AGE: 3Y
SHREVEPORT, LA 71107 SEX: F
PHONE: (318) 210-3821 RACE: BLACK OR AFRICAN AME
COUNTY: CADDOPARISH RELIGION: Other
MARITAL STAT: SINGLE

EMPLOYER: GOD'S GIFT PERSON TO NOTIFY: ALEXANDER, JENNIFER
ADDRESS: 2305 MARIAN PL ADDRESS: 2247 LEGARDY STREET
SHREVEPORT, LA 71109 SHREVEPORT, LA 71107
000-0000 PHONE: (318) 210-3821 RELATION: PARENT

Is the Patient here for Pre-Op Testing: N

Comments:

Reason for Visit: FEVER, WON'T EAT

Known Drug Allergies: A HIPPA Notice Given: Y Date Notice Given: 09/23/14 Admit Clerk: SAFFED2A
Interpreter ID Number: Patient Survey: U Preferred Language: ENGLISH Baby ID#: Device Id: AMSPC5
Do you have an advanced directive that you would like to present to us today? U Ethnicity: NHILAT



K20034103612

Physician Documentation

Willis Knighton South

Name: Aaliyah [REDACTED]
Age: 3 yrs Sex: Female DOB: 10/01/2013
Arrival Date: 09/23/2017 Time: 18:13
Bed 10

MRN: 1116206
Account#: K20034103612
Private MD: Allen, Scott

HPI:

09/23 This 3 yrs old Black/African Am Female presents to ED via Ambulatory with complaints of **Fever, Won't** sd5/eb4
18:33 **Eat**.
18:33 The patient reports fever, that was measured at 102 degrees Fahrenheit, with an emergency department sd5/eb4
temperature of 99.3 degrees Fahrenheit. Onset: The symptoms/episode began/occurred acutely,
yesterday. Modifying factors: there are no obvious modifying factors. Associated signs and symptoms:
Pertinent negatives: cough, diarrhea, hemoptysis, sinus congestion, sinus drainage, skin rash, swelling,
vomiting. Severity of symptoms: At their worst the symptoms were moderate in the emergency
department the symptoms are unchanged. The patient has not experienced similar symptoms in the past.
The patient has not recently seen a physician. Mother complains that Pt. hasn't eaten since yesterday.

Historical:

- **Allergies:** FISH PRODUCT DERIVATIVES (Hives); Codeine (Wheezing);
- **Home Meds:**
 1. Tylenol Oral as needed (Last dose: 09/23/2017 18:00)
 2. albuterol sulfate 1.25 mg/3 mL Inhl nebu as needed
 3. Dulera 100-5 mcg/actuation inhalation [REDACTED] 2 puffs 2 times per day
 4. Singulair 4 mg PO chew nightly
- **PMHx:** Asthma; Autism; nonverbal
- **PSHx:** None

Historical:

18:31 Family history: No immediate family members are acutely ill. amw3
18:31 Family history: Immunization history: Childhood immunizations up to date. amw3
18:33 The history from nurses notes was reviewed and confirmed. sd5/eb4

ROS:

18:33 ROS as in the HPI, and all other systems were reviewed negative, or noncontributory, except as sd5/eb4
mentioned below. **Eyes:** Negative for injury, pain, redness, and discharge, **ENT:** Negative for injury, pain,
and discharge, **Neck:** Negative for injury, pain, and swelling, **Cardiovascular:** Negative for chest pain,
palpitations, and edema, **Respiratory:** Negative for shortness of breath, cough, wheezing, and pleuritic
chest pain, **Abdomen/GI:** Negative for abdominal pain, nausea, vomiting, diarrhea, and constipation,
Back: Negative for injury and pain, **GU:** Negative for injury, bleeding, discharge, and swelling,
MS/Extremity: Negative for injury and deformity, **Skin:** Negative for injury, rash, and discoloration,
Neuro: Negative for headache, weakness, numbness, tingling, and seizure. **Constitutional:** Positive for
fever, Negative for body aches, coughing, obvious distress, acute pain, poor PO intake, shortness of
breath, vomiting.

Exam:

18:33 sd5/eb4

Head/Face: Normocephalic, atraumatic.

Eyes: Pupils equal round and reactive to light, extra-ocular motions intact. Lids and lashes normal.
Conjunctiva and sclera are non-icteric and not injected. Cornea within normal limits. Periorbital areas with
no swelling, redness, or edema.

Neck: Trachea midline, no thyromegaly or masses palpated, and no cervical lymphadenopathy. Supple,
full range of motion without nuchal rigidity, or vertebral point tenderness. No Meningismus. Lymphatic No
abnormal lymphadenopathy noted by palpation in the neck or axilla

Chest/axilla: Normal symmetrical motion. No tenderness. No crepitus. No axillary masses or tenderness.

Cardiovascular: Regular rate and rhythm with a normal S1 and S2. No gallops, murmurs, or rubs.
Normal PMI, no JVD. No pulse deficits.

Respiratory: Lungs have equal breath sounds bilaterally, clear to auscultation and percussion. No rales,
rhonchi or wheezes noted. No increased work of breathing, no retractions or nasal flaring.

Physician Documentation Con't.

Abdomen/GI: Soft, non-tender with normal bowel sounds. No distension, tympany or bruits. No guarding, rebound or rigidity. No palpable masses or evidence of tenderness with thorough palpation.

Back: No spinal tenderness. No costovertebral tenderness. Full range of motion.

Skin: Warm and dry with excellent turgor. capillary refill <2 seconds. No cyanosis, pallor, rash or edema.

MS/ Extremity: Pulses equal, no cyanosis. Neurovascular intact. Full, normal range of motion.

Neuro: Awake and alert, GCS 15, oriented to person, place, time, and situation. Cranial nerves II-XII grossly intact. Motor strength 5/5 in all extremities. Sensory grossly intact. Cerebellar exam normal. Normal gait.

Constitutional: The patient appears Blood pressure, pulse, respirations and temperature noted. awake, alert, well developed, well hydrated, well nourished, non-diaphoretic, febrile, ED temp noted to be 99.3.

ENT: External ear(s): are unremarkable, no erythema, no cellulitis, no abscess, no swelling, Ear canal(s): are normal, clear, no abscess, no bleeding, no bloody discharge, no cerumen impaction, no erythema, no foreign body, no purulent discharge, no swelling, TM's: bulging, is not appreciated, decreased mobility, is not appreciated, dullness, is not appreciated, erythema, that is moderate, on the left, fluid levels, is not appreciated, hemotympanum, is not appreciated, loss of bony landmarks, is not appreciated, rupture, is not appreciated, Nose: is normal, no bleeding, no clotted blood, no drainage, no edema, no erythema, no septal hematoma, no swelling, Mouth: is normal, no gum abnormalities, no lip abnormalities, no mucosal abnormalities, no tongue abnormalities, Posterior pharynx: is normal, airway is patent, no erythema, no exudate, no swelling.

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Height	Pain	Staff
18:17		160	28	99.3(TE)	96%	15.42 kg / 34 lbs 0 oz	30 in. (76.20 cm) (M)	4/10	clk

18:17 Body Mass Index 26.56 (15.42 kg, 76.20 cm)

clk

Glasgow Coma Score:

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
18:17	to voice(3)	confused(4)	localizes pain(5)		12	clk

MDM:

18:27 Patient medically screened.

sd5

18:33

sd5/eb4

Data reviewed: vital signs, nurses notes, radiologic studies, plain films, and as a result, I will continue to observe the patient, order radiologic study(s).

Counseling: I had a detailed discussion with the patient and/or guardian regarding: the historical points, exam findings, and any diagnostic results supporting the discharge/admit diagnosis, radiology results, the need for outpatient follow up, to return to the emergency department if symptoms worsen or persist or if there are any questions or concerns that arise at home.

19:15

sd5

Differential diagnosis: bacterial infection, bronchitis, fever, URI, viral infection, otitis media.

Response to treatment: There is no appreciated change of the patient's symptoms at this time, the patient's symptoms have mildly improved after treatment.

Order	Status	Time	By	For
Chest 2:View *routine*	Ordered	09/23/17 18:33	sd5	sd5
	In Process Unspecified	09/23/17 18:50	Dispatcher MedHost	
Notes: Bed Name: 10	Order Method: Electronic			
ER EXAM ROOM/BED: (OERDERRMBD): 10				

Name: Aaliyah [REDACTED]

MRN: 1116206

Account#: K20034103612

Print Time: 9/24/2017 21:27:08

Page 2 of 3

Physician Documentation Con't.

Is the patient able to bear weight? (OERDBEARWT):
Is the patient at risk for falls? (OERDFALLS):
MODE OF TRANSPORTATION : (OERDTRANS): Stretcher
O2: (OEADO2): No
Priority RAD: Stat
REASON FOR EXAM: (OERDEXAM): Fever, Won't Eat
WEIGHT? : (OERDWEIGHT): 15.42

Order Signatures:

Denham, Sean, MD MD sd5

Scribe Statement:

09/23

18:33 Scribed for **Dr. Sean Denham, MD** by Emily Bender, Scribe

sd5/eb4

Disposition:

19:15 Electronically signed by: Sean C. Denham, MD. I personally performed the services described in this documentation as scribed in my presence and it is both accurate and complete. Disposition.

sd5

Disposition:

09/23/17 19:17 Discharged to Home/Self Care. Impression: Otitis media, unspecified.

- Condition is Stable.
- Discharge Instructions: Otitis Media, Pediatric.
- Prescriptions for
Amoxicillin 400 mg/5 mL Oral Suspension for Reconstitution
- take 9 milliliter by ORAL route every 12 hours for 10 days MAX dose = 1750mg/day; 180 milliliter.
- Follow up: Allen, Scott; When: ASAP; Reason: Recheck today's complaints.
- Problem is new.
- Symptoms are unchanged.

Signatures:

Dispatcher MedHost
Kelley, Candes, RN
Bender, Emily, Scribe

EDMS
RN clk
Scribe eb4

Denham, Sean, MD
Wooten, Alexi, RN

MD sd5
RN amw3

Name: Aaliyah [REDACTED]

Print Time: 9/24/2017 21:27:08

MRN: 1116206
Account#: K20034103612
Page 3 of 3

Nurse's Notes

Name: Aaliyah [REDACTED]
Age: 3 yrs **Sex:** Female **DOB:** 10/01/2013
Arrival Date: 09/23/2017 **Time:** 18:13
Bed 10

Willis Knighton South

MRN: 1116206
Account#: K20034103612
Private MD: Allen, Scott

Presentation:

09/23 Method of Arrival: Ambulatory. clk
 18:14 Preferred language for medical communication is English. Presenting complaint: Mother states: " fever and wont eat for 24 hours. ". Person Transporting: Parent. Transition of care: patient was not received from another setting of care. Mechanism of Injury: denies injury. Care prior to arrival: Medications: Tylenol. clk
 18:19 Acuity: 4 - Semi-Urgent. clk

Triage Assessment:

18:16 **General:** Appears well developed, well nourished, well groomed, Behavior is cooperative, appropriate for age, pleasant, mobility; ambulates without assistance Reports fever for wont eat for 24 hours. **Pain:** Complains of pain in throat Faces, Legs, Activity, Cry, Consolability scale score is 4 out of 10. clk

Historical:

- **Allergies:** FISH PRODUCT DERIVATIVES (Hives); Codeine (Wheezing);
- **Home Meds:**
 1. Tylenol Oral as needed (Last dose: 09/23/2017 18:00)
 2. albuterol sulfate 1.25 mg/3 mL Inhl nebu as needed
 3. Dulera 100-5 mcg/actuation inhalation [REDACTED] 2 puffs 2 times per day
 4. Singulair 4 mg PO chew nightly
- **PMHx:** Asthma; Autism; nonverbal
- **PSHx:** None

Historical:

18:31 Family history: No immediate family members are acutely ill. amw3
 18:31 Family history: Immunization history: Childhood immunizations up to date. amw3
 18:33 The history from nurses notes was reviewed and confirmed. sd5/eb4

Screening:

18:16 **Abuse screen:** Denies threats or abuse. Denies injuries from another. clk
Patient fall risk assessment: risks identified; None.
Learning Barriers: the patient has a cognitive barrier to learning caregiver ready and willing to learn.
Pedi Fall Risk Neuro Deficit Yes (1 Pt.).
Exposure risk/Travel Screening: None identified.

Assessment:

18:31 **Pain:** level that is acceptable is 0 out of 10 on a pain scale. FACES pain scale score is 6 out of 10. amw3
General: Appears well developed, well nourished, well groomed, uncomfortable, mobility; ambulates without assistance. **Neuro:** Level of Consciousness is alert, awake. **EENT:** No deficits noted. **Respiratory:** Respiratory effort is even, unlabored, Respiratory pattern is regular, symmetrical, Airway is patent.
Gastrointestinal: Abdomen is flat, non-distended Bowel sounds present X 4 quads. Abd is soft X 4 quads Parent/caregiver reports the patient having mother states patient is not wanting to eat. **Genitourinary:** Reports normal urinary habits. **Dermatologic:** Skin is intact, is healthy with good turgor, Skin is dry, Skin is normal, black, Skin temperature is warm. **Musculoskeletal:** No deficits noted.

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Height	Pain	Staff
18:17		160	28	99.3(TE)	96%	15.42 kg / 34 lbs 0 oz	30 in. (76.20 cm) (M)	4/10	clk

18:17 Body Mass Index 26.56 (15.42 kg, 76.20 cm) clk.

Vitals:

Nurse's Notes Con't

18:17 Acuity: 4 - Semi-Urgent.

clk

Glasgow Coma Score:

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
18:17	to voice(3)	confused(4)	localizes pain(5)		12	clk

ED Course:

18:13 Patient arrived in ED. ms2
 18:13 Patient moved to KIOSK. ms2
 18:14 Allen, Scott is Private Physician. clk
 18:19 Patient moved to Waiting. clk
 18:19 Patient placed in waiting room Patient notified of wait time. clk
 18:22 Patient moved to .HB5. amw3
 18:26 Patient moved to 10. smc
 18:27 Denham, Sean, MD is Attending Physician. sd5
 18:29 Wooten, Alexi, RN is Primary Nurse. amw3
 18:33 Patient/caregiver encouraged to voice any concerns. Side rails up X 1. Bed in low position. Call light in reach. Patient has correct armband on for positive identification. Adult with patient. amw3
 19:16 Allen, Scott is Referral Physician. sd5
 19:26 No procedures done that require assistance. amw3

Administered Medications:

No medications were administered

Outcome:

19:17 Discharge ordered by MD. sd5
 19:26 Discharged to home, ambulatory, with family. Discharge instructions given to Mother Instructed on discharge instructions, follow up and referral plans, medication usage, Demonstrated understanding of instructions, medications, Prescriptions given; 1, No questions or concerns expressed to me at discharge. No belongings were removed by WK staff. **Medication reconciliation form provided. Med Effects:** Patient recieved no medications during this visit. **Oxygen use:** Oxygen use not applicable. amw3
 19:26 Electronic medical record closed. amw3

Signatures:

Clinger, Steven, RN	RN	smc	Scriptuser, MEDHOST	ms2
Denham, Sean, MD	MD	sd5	Kelley, Candes, RN	RN clk
Wooten, Alexi, RN	RN	amw3	Bender, Emily, Scribe	Scribe eb4

Name: Aaliyah [REDACTED]

MRN: 1116206
Account#: K20034103612

Print Time: 9/24/2017 21:27:07

Page 2 of 2

Willis-Knighton South
2510 Bert Kouns Industrial Loop
Shreveport, LA 71118

Patient Name: [REDACTED]
Adm No: K20034103612
DOB: 10/01/2013
Age: 3Y F
Corp ID: 000001116206

MRN: 1116206
Location: ER Patient --
Ord No: 90019
Hospital: WKS

Ordering Dr: SEAN CHRISTOPHER DENHAM

CC:

Final Report

Admitting Diagnosis: FEVER, WON'T EAT
Reason For Exam: Fever, Won't Eat
Procedure Date: 09/23/2017
Procedure: SXR - XR, chest 2 view

Interpretive Location:
Accession Number: 3792430
CPT Code: 71020

IMPRESSION: No acute cardiopulmonary disease.

RESULT:

Procedure: XR, chest 2 view

Clinical Information: Fever, Won't Eat

Comparison: 9/16/2017

Findings:

Heart size and contour are within normal limits. The lungs are clear of infiltrate, mass lesion, or effusion. No significant skeletal abnormality is seen.

Electronically Signed by: MICHAEL COLTER GATES M.D. on Sep 23 2017 7:36P

Techs: Jaime S Rivers
Additional Staff:

Read by: MICHAEL COLTER GATES M.D. on Sep 23 2017 7:35P
Electronically Signed by: MICHAEL COLTER GATES M.D. on Sep 23 2017 7:36P

Printed: Sep 23 2017 7:40PM

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Plan Of Care Report

Generated from 08/24/2017 00:00 to 09/07/2017 23:59

Pt Name: [REDACTED] L MRN: 1116206
Pt ID: 0101757329 Acct No: K20034103612
DOB: 10/01/2013 Age/Sex: 3Y/F
Adm DTime: 09/23/2017 18:13 Atn Dr: Denham, Sean MD
Nurs Sta: Willis-Knighton South Rm & Bed:
Dx:
Alrg: codeine, Fish Containing Products, Fish containing products

Plan of Care

No Plans Charted for Visit

Problems associated to Patient

Problem Name	Rank	Date Assigned	Date Closed	Assigned By	Closed By	Status
Problem Details	Value	Problem Details	Value	Problem Details	Value	
Breathing Pattern - Ineffective		08/28/2017 04:31		Meghan A Wallace, RN		Resolved
Status:						
Falls - Risk of		08/28/2017 04:31		Meghan A Wallace, RN		Resolved
Comment:		Status:				
Thermoregulation - Risk of,		08/28/2017 04:31		Meghan A Wallace, RN		Resolved
Impaired						
Comment:		Event:		Day Part:		
Severity:		Acute/Chronic:		Onset Date:		
Onset:		Status:				

Expected Outcomes

No Expected Outcomes Charted For Visit

Pt Name: [REDACTED] L
Rm/ Bed:

MRN: 1116206
Page 1 of 1

Plan Of Care Report
ORE_0146_DSCH_NBR_v1.rpt v1.00
Printed By :Workflow
Printed On: 24-Sep-17 19:40

ALLERGY REPORT

Pt Name: [REDACTED] L MRN: 1116206
Pt ID: 0101757329 Acct No: K20034103612
DOB: 10/01/2013 Age/Sex: 3Y/F
Adm DTime: 09/23/2017 18:13 Atn Dr: Denham, Sean MD
Nurs Sta: Willis-Knighton South Rm & Bed:
Dx:
Alerg: codeine, Fish Containing Products, Fish containing products

Alerg Type	Alerg Name	Onset	Reaction	Severity	Comment
Drug	codeine	7/14/2017	Shortness of Breath	Severe	"Took codeine yesterday. Started wheezing, couldnt breathe like she was having an asthma attack"
Drug	Fish Containing Products	05/2017	Anaphylaxis	Severe	Patient severely allergic. Reaction when touches seafood
Food	Fish containing products	05/2017	Anaphylaxis	Severe	Patient severely allergic. Reaction when touches seafood

Pt Name: [REDACTED] L
Rm/ Bed:

MRN: 1116206
Page 1 of 1

Allergy Report
ORE_0109_DSCH_NBR.rpt v1.00
Printed By :Workflow
Printed On: 24-Sep-17 19:40

RUN DATE: 09/23/17
RUN TIME: 1820
RUN USER: SAFFED2.AM

Willis Knighton South *ADMISSION
INTERDISCIPLINARY ALLERGY SOURCE DOCUMENT

PAGE 1

Name: [REDACTED] L DOB: 10/01/13 Age: 3Y 11M
Rm/Bd: Serv/Loct: ERS Status: ER Sex: F
Unit#: K000629604 Account#: K20034103612 EPI#: 000000001116206

Last Update/
Acknowledgement:

Interdisciplinary Assessment (Free Text), historical data:

Allergy1-Med/Contact: NKDA	11/04/16 - 2201
Allergy2-Med/Contact: NKDA	11/04/16 - 2201
Food Allergies-Intol: NKFA	11/04/16 - 2201
Latex Allergy (Y/N): N	11/04/16 - 2201


Pharmacy Allergy List (Coded Allergies), historical data:

11/06/16

(Duplicate names represent coding within (3) categories:
Ingredient, Generic and Class allergy codes.)

NO KNOWN DRUG ALLERGIES, NO KNOWN FOOD ALLERGIES, NO KNOWN LATEX ALLERGY

Interdisciplinary Allergy Source Document is a Permanent Part of
the Patient's Medical Record


[REDACTED] IYAH L
10/01/13 3Y 11M
Brandhurst, Roy E M
K20034103612 09/23/17

Willis Knighton South and Center for Womens Health

Willis Knighton South
2510 Bert Kouns Industrial Loop
Shreveport, LA 71118
318-212-5500

**Discharge Instructions for:**

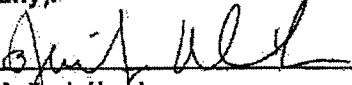
Arrival Date: 09/23/2017 18:13
Care Complete Time: 09/23/2017 19:17

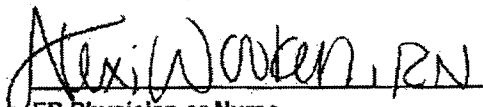
Thank you for choosing Willis Knighton South for your care today. The examination and treatment you have received in the Emergency Department today have been rendered on an emergency basis only and are not intended to be a substitute for an effort to provide complete medical care. You should contact your follow-up physician as it is important that you let him or her check you and report any new or remaining problems since it is impossible to recognize and treat all elements of an injury or illness in a single emergency care center visit.

Care provided by: Denham, Sean, MD**Diagnosis:** Otitis media, unspecified

DISCHARGE INSTRUCTIONS	FORMS
Otitis Media, Pediatric	None
FOLLOW UP INSTRUCTIONS	PRESCRIPTIONS
Allen, Scott When: ASAP; Reason: Recheck today's complaints	Amoxicillin
SPECIAL NOTES	
None	

I hereby acknowledge that I have received and understand the above instructions and prescriptions (if any).


Aaliyah Henderson
MRN # 1116206


ED Physician or Nurse


X-RAYS and LAB TESTS:

If you had x-rays today they were read by the emergency physician. Your x-rays will also be read by a radiologist within 24 hours. If you had a culture done it will take 24 to 72 hours to get the results. If there is a change in the x-ray diagnosis or a positive culture, we will contact you. Please verify your current phone number prior to discharge at the check out desk.

MEDICATIONS:

If you received a prescription for medication(s) today, it is important that when you fill this you let the pharmacist know all the other medications that you are on and any allergies you might have. It is also important that you notify your follow-up physician of all your medications including the prescriptions you may receive today.

Chart Copy


HENDERSON, AALIYAH L
10/01/13 3Y 11M
Brandhurst, Roy E M
K20034103612 09/23/17

FOLLOW UP INSTRUCTIONS

Allen, Scott

When: ASAP

Reason: Recheck today's complaints

PRESCRIPTIONS

Amoxicillin 400 mg/5 mL Oral Suspension for Reconstitution

Printed

Take 9 milliliter by ORAL route every 12 hours for 10 days MAX dose = 1750mg/day; Quantity: 180 milliliter

TESTS AND PROCEDURES

Labs

None

Rad

Chest 2 View *routine*

Procedures

None

Other

None



RENDERSON [REDACTED] L
10/01/13 3Y 11M
Brandhurst, Roy E M
K20034103612 09/23/17



ASSIGNMENT OF BENEFITS

1. Hospital Care Consent: I/we consent to hospital services, treatment and diagnostic procedures by the hospital as may be deemed necessary or advisable by my physician and/or consultants selected by my physician. The consent to hospital care includes permission for x-ray examinations, laboratory procedures, I.V. treatments, hepatitis test administration of blood and blood products, injections, medications, recording, filming or video monitoring for internal purposes only, and hospital services rendered the patient under the general and special instruction of doctors. The patient acknowledges responsibility for any or all of these procedures. It is the hospital policy that the patient has the opportunity to discuss surgery and procedures with the patient's doctor before hand. The patient has the right to consent to surgery and procedures. Except in emergencies or unusual circumstances, the hospital does not allow its facilities to be used without this discussion and patient's consent. I voluntarily give my consent to hospital care and accept the condition of hospitalization listed.

2. Authorizations for Release of Information: The employees and agents of this hospital and copy services and electronic claims processing services under contract with this hospital and any third party billing agents for this hospital or any of its staff physicians involved with patient care are given permission to release any and all information relating to the patient, including but not limited to the medical record of the patient's hospitalization, to another healthcare provider if the patient was transferred to that facility from this hospital and to any and all insurance companies or other third-party paying or obligated to pay, in whole or in part, the charges incurred by the patient in this hospital; and they are also given permission to release the above described information to any agent or firm working for or with the above described insurance companies or other third-party payors for the purpose of performing pre-certification, concurrent and/or retrospective review and/or other utilization review of any kind.

3. Valuables: I understand and acknowledge that the hospital assumes no responsibility for personal possessions including cash, jewelry, bridgework, eyeglasses or any other personal possession which I choose to keep in my room. I have been advised that such valuables should be placed in the care of my family or deposited in the hospital vault located in the Business Office.

4. Safety Code for Hospital: Safety Codes for hospitals issued by the National Fire Protection Association prevent the use in the hospital of any electrical equipment or accessories until they have been safety checked by the hospital's electrical engineer. Exceptions to this rule are hair and blow dryers, curling irons, hot rollers, radios, clocks, electric razors, shavers, contact lens sterilizers, electric toothbrushes and calculators.

5. Payment Guaranty and Assignment of Insurance Benefits: I, the undersigned patient, guardian, and/or guarantor (hereinafter "Debtor") hereby promise to pay in full Willis-Knighton Health System (WKHS) customary charges for the goods and services rendered to the patient identified on the reverse side hereof during this period of hospitalization (hereinafter "Indebtedness"). Debtor acknowledges and agrees that, unless waived in full by WKHS as set forth below, the Indebtedness accruing during this hospitalization is due and payable in such amounts and at such times during this hospitalization as WKHS may, in its sole discretion, determine, that the entire Indebtedness is due and payable in full at discharge. I acknowledge that, upon proof of acceptable insurance coverage, WKHS, in its sole discretion, may reduce the amount of indebtedness due and payable during this hospitalizations and the balance due at discharge. In such event, I understand that all deductibles, co-insurance, non-covered charges and other items not paid by insurance or other third-party payors shall be due and payable during this period of hospitalization and upon discharge as set forth hereinabove. I acknowledge and agree that in the event that WKHS, in its sole discretion, accepts proof of insurance coverage, claims for payment for benefits will be filed on behalf of the Debtor and/or the insured and that these benefits will be considered by WKHS in determining the amounts due as set forth hereinabove. I understand and agree that WKHS will accept payments from third-party payors and insurers on behalf of the Debtor and apply such payment to the indebtedness to the extent that they are received. I acknowledge and agree that the filing of such insurance and other third-party claims is performed as a service by WKHS and in no way relieves me of the obligation to pay the Indebtedness as agreed herein above.

Patient hereby appoints WKMC as Patient's authorized representative to file any necessary claim appeal(s) on Patient's behalf. In consideration for this appointment, WKMC agrees only to collect only applicable copayments, deductibles, and coinsurance for covered benefits from the Patient and waives any right to collect any other payments related to those covered benefits from the Patient.

Debtor hereby absolutely assigns to WKHS all insurance benefits on all policies of insurance under which Debtor is an insured, whether hospital, medical, liability or other insurance, and also hereby absolutely assigns to WKHS the proceeds of any judgment or settlement of any claim against any third party and any and all other amounts which may be determined in any manner to be payable to Debtor in connection with any injury suffered by the patient which gives rise to the Indebtedness incurred during this period of treatment. I hereby authorize WKHS to obtain any and all information related to such injuries, including, but not limited to, accident reports and agree to cooperate with WKHS in connection with the procurement of any information or documents WKHS deems in its sole discretion, necessary or appropriate in connection with the assignment made pursuant to this paragraph. I hereby authorize and direct that all such payments and proceeds shall be made directly to WKHS under the terms of this assignment. Any receipts from WKHS shall be applied towards Indebtedness but such application shall not relieve the Debtor from the Debtor's obligation to pay any remaining portion to the Indebtedness. Debtor acknowledges and agrees that, to the extent that the Indebtedness has not been satisfied by such receipts, that portion of the Indebtedness for which payment has been deferred pursuant to the preceding paragraph shall be due and payable in full on the thirtieth day following the date of service. In the event that WKHS receives proceeds and/or payments in excess of the Indebtedness, WKHS may apply such excess payment to any outstanding Indebtedness of Debtor to WKHS arising out of any other period(s) of treatment as well as any attorneys' fees and expenses for which Debtor may be liable hereunder. In the event that all Indebtedness has been paid

Admission Date: 09/23/17

Admission Time: 1813



AM0005



10/01/13 3Y F
 Branchurst, Roy E M.D.
 K20034103612 09/23/17



ASSIGNMENT OF BENEFITS

in full, then WKHS will refund the Debtor any such excess payment. Notwithstanding anything herein to the contrary, the assignments made hereby shall remain in full force and effect until the entire Indebtedness and any and all attorneys' fees and expenses for which Debtor may be liable have been paid in full. In the event that the Indebtedness is not paid when and as due as determined by WKHS hereunder, and the Indebtedness is placed in the hands of an attorney for purposes of collection, Debtor agrees to pay reasonable attorneys' fees, which are hereby acknowledged to be one-third (1/3) of the amount of the Indebtedness at the time the matter is placed in the hands of an attorney, plus any and all court costs and other expenses incurred in connection with the collection of the Indebtedness.

Financial assistance is available to all patients who meet the requirements of our charity care policy. Patients are encouraged to contact the Business Office if they have any concerns or need assistance in paying their bills. Our charity care policy is limited to hospital charges and does not include physician, anesthesiologist or professional charges that are not billed by the hospital. In addition, financial assistance is not offered for cosmetic, elective, experimental or other treatments and all hospital services must be ordered by your physician.

6. Assignment to Physicians: I understand that my physician as well as other physicians who treat me or otherwise involved in my care while a patient at the hospital are not employees or agents of the hospital and the hospital is not responsible for their actions. I further understand that my physician or other physicians will send me a separate bill for their services, in addition to the hospital bill. I hereby assign to all physicians who treat me the benefits due to me for these services covering medical and/or surgical expenses. I agree that should be the amount be insufficient to cover the entire medical/surgical expense, I will be responsible to said physicians for payment of the entire bill.

7. Medicare Consent: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act (SSA) is correct. I authorize Willis-Knighton Health System (WKHS) to provide (SSA) or its intermediaries with access to my medical/hospital record for the purpose of processing the Medicare claim for this or a related Medicare claim. I further request that WKHS provide such copies thereof as may be requested. Copies may be made by WKHS or its agents or contractors providing copy service and electronic claims processing services and said third party billing agents for hospital and staff physicians involved with patient care.

8. Champus/Medicare Notice: Champus/Medicare will not pay for private rooms unless medical justified, personal convenience items, diagnostic admissions or test or hospital stays not medically necessary. My signature below acknowledges my receipt of this information regarding Champus/Medicare from the hospital on the date indicated.

9. Willis-Knighton Health System (and our Medical Staff) will use and disclose your personal health information to treat you, to receive payment for the care we provide and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website and have copies available for distribution. I acknowledge that I have received a copy of the Notice of Privacy Practices.

This form has been fully explained to me. My signature reflects my understanding of the information contained herein. I further understand and acknowledge that all references to myself as the patient shall be deemed to apply as if rewritten in their entirety to a dependent for whom I am responsible for and/or who is unable to consent on their behalf for reasons indicated below.

I acknowledge that I have been informed of my rights and obligations as a patient.

 Signature of Patient/Guardian	 Date/Time	 Guarantor	 Date/Time	 Witness	 Date/Time
 Print Name		 Print Name		 Print Name	 Date/Time

If Patient/Guarantor is unable to sign, I, _____, do hereby state that I have been given the authority to sign for

_____, either expressed or implied and that he or she is fully aware of this authority.

Signature of Authorized Party	Authorized Party's Relationship to the Patient	Date/Time	Witness	Date/Time
----------------------------------	---	-----------	---------	-----------

Admission Date: 09/23/17
Admission Time: 1813



AM0005



10/01/13 3Y F
Brandhurst, Roy E M.D.
K20034103612 09/23/17

WILLIS TOWSON MEDICAL CENTER

SHREVEPORT, LA

EMERGENCY ROOM REGISTRATION INFORMATION (3008)

NAME: [REDACTED] L

ACCT. NO: K20034078160

GUARANTOR: ALEXANDER, JENNIFER

NEXT OF KIN: ALEXANDER, JENNIFER

ADDRESS: 2247 LEGARDY STREET
SHREVEPORT, LA 71107ADDRESS: 2247 LEGARDY STREET
SHREVEPORT, LA 71107

PHONE: (318)210-3821

PHONE: (318)210-3821

RELATION: PARENT

GUAR EMPLOYER: CHILD

ADDRESS:

ARRIVED FROM: C

ATTENDING PHYS: Easterling, David R.M.D.

PHONE:

ADMIT/OTHER PHYS:

PRIM CARE PHYS:

	NAME	POLICY #	GROUP #	BENEFIT PLAN
PRIMARY INS:	LA HLTHCARE CONN LA ME	1997286459512	[REDACTED] L	MEDICAID
SECONDARY INS:				
TERTIARY INS:				
FOURTH INS:				

ACCT NO: K20034078160

DATE: 09/16/17

UNIT#: K000629604

ROOM:

TIME: 0851

F/C: MA

STATUS: REG ER

SERV/LOC: ERS

SS#: 338-89-3614

PATIENT: [REDACTED] L

BIRTHDATE: 10/01/13

ADDRESS: 2247 LEGARDY STREET
SHREVEPORT, LA 71107

AGE: 3Y

SEX: F

PHONE: (318)210-3821

RACE: BLACK OR AFRICAN AME

RELIGION: Other

COUNTY: CADDOPARISH

MARITAL STAT: SINGLE

EMPLOYER: GOD'S GIFT

PERSON TO NOTIFY: ALEXANDER, JENNIFER

ADDRESS: 2305 MARIAN PL
SHREVEPORT, LA 71109ADDRESS: 2247 LEGARDY STREET
SHREVEPORT, LA 71107

000-0000

PHONE: (318)210-3821

RELATION: PARENT

Is the Patient here for Pre-Op Testing: N

Comments:

Admit Clerk: ALEXAJAM

Reason for Visit: COUGH FEVER

Baby ID#:

Known Drug Allergies: A

HIPAA Notice Given: Y

Date Notice Given: 09/23/14

Device Id: AMSPC6

Interpreter ID Number:

Patient Survey: N

Preferred Language: ENGLISH

Ethnicity: NHILAT

Do you have an advanced directive that you would like to present to us today? N



K20034078160

Physician Documentation

Willis Knighton South

Name: Aaliyah [REDACTED]
Age: 3 yrs Sex: Female DOB: 10/01/2013
Arrival Date: 09/16/2017 Time: 08:42
Bed 10

MRN: 1116206
Account#: K20034078160
Private MD: Allen, Scott

HPI:

09/16 This 3 yrs old Black/African Am Female presents to ED via Ambulatory with complaints of **Cough, Fever.** dre/kej
09:09 The patient presents to the emergency department with congestion, that is moderate, cough, described as moderate, fever, that is subjective. Onset: The symptoms/episode began/occurred 2 day(s) ago. dre/kej
Associated signs and symptoms: Pertinent positives: congestion, cough, fever, Pertinent negatives: abdominal pain, constipation, diarrhea, earache, shortness of breath, sore throat, vomiting, wheezing.
Modifying factors: The patient symptoms are alleviated by nothing, the patient symptoms are aggravated by nothing. Treatment prior to arrival: none. The patient has experienced similar episodes in the past, with the last episode occurring 2 week(s) ago. The patient has been recently been admitted at Willis Knighton, was discharged a couple of weeks ago. Pt recently discharged 2 weeks ago seen "lung doctor per family" given breathing treatment and steroid inhaler. Family reports using both. .

Historical:

- **Allergies:** No known drug Allergies;

Historical:

09:09 The history from nurses notes was reviewed and confirmed. Social history: The patient attends recently started., the patient is a minor. dre/kej
09:24 Family history: Pertinent for; cancer, diabetes, hypertension, pertinent negatives; thyroid disease, No immediate family members are acutely ill. Immunization history: Childhood immunizations up to date. eb1
Social history: The patient lives at home with family The patient/guardian denies using caffeine The patient speaks fluent English.

ROS:

09:09 ROS as in the HPI, and all other systems were reviewed negative, or noncontributory, except as mentioned dre/kej below. **Eyes:** Negative for injury, pain, redness, and discharge, **Neck:** Negative for injury, pain, and swelling, **Cardiovascular:** Negative for chest pain, palpitations, and edema, **Abdomen/GI:** Negative for abdominal pain, nausea, vomiting, diarrhea, and constipation, **Back:** Negative for injury and pain, **GU:** Negative for injury, bleeding, discharge, and swelling, **MS/Extremity:** Negative for injury and deformity, **Skin:** Negative for injury, rash, and discoloration, **Neuro:** Negative for headache, weakness, numbness, tingling, and seizure, **Psych:** Negative for depression, anxiety, suicide ideation, homicidal ideation, and hallucinations. **Constitutional:** Positive for coughing, fever, Negative for body aches, chills, fussiness, obvious distress, acute pain, poor PO intake, shortness of breath, vomiting. **ENT:** Positive for sinus congestion, Negative for difficulty swallowing, nose bleed, pulling at ears, sore throat. **Respiratory:** Positive for cough, with no reported sputum, Negative for hemoptysis, shortness of breath, wheezing.

Exam:

09:09 dre/kej

Head/Face: Normocephalic, atraumatic.

Eyes: Pupils equal round and reactive to light, extra-ocular motions intact. Lids and lashes normal. Conjunctiva and sclera are non-icteric and not injected. Cornea within normal limits. Periorbital areas with no swelling, redness, or edema.

ENT: Nares patent. No nasal discharge, no septal abnormalities noted. Tympanic membranes are normal and external auditory canals are clear. Oropharynx with no redness, swelling, or masses, exudates, or evidence of obstruction, uvula midline. Mucous membrane moist

Neck: Trachea midline, no thyromegaly or masses palpated, and no cervical lymphadenopathy. Supple, full range of motion without nuchal rigidity, or vertebral point tenderness. No Meningismus. Lymphatic No abnormal lymphadenopathy noted by palpation in the neck or axilla

Chest/axilla: Normal symmetrical motion. No tenderness. No crepitus. No axillary masses or tenderness.

Cardiovascular: Regular rate and rhythm with normal S1 and S2. no murmurs, rubs or gallops. Pulses intact and symmetrical throughout. No edema or JVD.

Physician Documentation Con't.

Respiratory: CTA with excellent breath sounds in all fields. Symmetrical chest wall movement with no wheezing, rales, or rhonchi. No evidence of stridor or nasal flaring. No increased work of breathing.

Abdomen/GI: Soft, non-tender, nondistended, no mass, no hepatosplenomegaly. No rebound or guarding. Bowel sounds present all quadrants. No hernia noted

Back: No spinal tenderness. No costovertebral tenderness. Full range of motion.

Skin: Warm and dry with excellent turgor. capillary refill <2 seconds. No cyanosis, pallor, rash or edema.

MS/ Extremity: Pulses equal, no cyanosis. Neurovascular intact. Joints show full, normal range of motion. Good muscle tone and strength. No acute changes of nails or digits

Neuro: Awake or easily awakened, alert, makes good eye contact, age appropriate reflexes, good tone, easily consolable.

Psych: Behavior, mood, response, and affect are appropriate for age.

Female GU: Normal external genitalia. Bladder is nontender.

Constitutional: The patient appears Blood pressure, pulse, respirations and temperature noted. awake, alert, well groomed, non-diaphoretic, afebrile.

Special observations: Pt playing on phone during exam..

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Height	Pain	Staff
08:43		135	28	98.4	100% on R/A	16.78 kg / 36 lbs 16 oz	36 in. (91.44 cm)	0/10	js

08:43 Body Mass Index 20.07 (16.78 kg, 91.44 cm)

js

Glasgow Coma Score:

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
08:43	spontaneous(4)	oriented(5)	obeys commands(6)		15	js

MDM:

09:09

dre/kej

Data reviewed: vital signs, nurses notes, and as a result, I will continue to observe the patient, order radiologic study(s), plain X-ray(s).

Data interpreted: Pulse oximetry: normal.

Counseling: I had a detailed discussion with the patient and/or guardian regarding: the historical points, exam findings, and any diagnostic results supporting the discharge/admit diagnosis, radiology results, the need for outpatient follow up, to return to the emergency department if symptoms worsen or persist or if there are any questions or concerns that arise at home.

09:14 Patient medically screened.

dre

10:02

dre

Differential diagnosis: bacterial infection, bronchitis, fever, pneumonia URI, UTI, viral infection.

Order	Status	Time	By	For
Chest 2 View *routine*	Ordered	09/16/17 09:15	dre	dre
	Reviewed	09/16/17 10:01	David Easterling	
Notes: Bed Name: 10	Order Method: Electronic			
Interpretation: VIRAL PATTERN, OTHERWISE NEGATIVE .				
WEIGHT?: (OERDWEIGHT): 16.78				
ER EXAM ROOM/BED: (OERDERRMBD): 10				
Is the patient able to bear weight? (OERDBEARWT):				
Is the patient at risk for falls? (OERDFALLS):				

Name: Aaliyah [REDACTED]

MRN: 1116206

Account#: K20034078160

Print Time: 9/17/2017 12:24:27

Page 2 of 3

Physician Documentation Con't.

MODE OF TRANSPORTATION : (OERDTRANS): Stretcher				
O2: (OEADO2): No				
Priority RAD: Stat				
REASON FOR EXAM: (OERDEXAM): Cough, Fever				
Order	Status	Time	By	For
Call X-Ray Tech	Ordered	09/16/17 09:15	dre	dre
	Completed	09/16/17 09:54	Edward Bentrup	
Notes:	Order Method: Electronic			

Order Signatures:

Easterling, David, MD MD dre

Scribe Statement:

09/16
09:08 Scribed for **Dr. David R Easterling, MD** by Katherine E Jaynes, Scribe dre/kej

09/16
09:11 Scribed for **Dr. David R Easterling, MD** by Kerri L Barlow, Scribe dre/klb2

Disposition:

10:02 Electronically signed by: David Easterling, M.D. I personally performed the services described in this documentation as scribed in my presence and it is both accurate and complete. Disposition. dre

Disposition:

09/16/17 10:03 Discharged to Home/Self Care. Impression: .URI Acute upper respiratory infection, unspecified.

- Condition is Stable.
- Discharge Instructions: Upper Respiratory Infection, Pediatric.
- Follow up: Private Physician; When: Next week; Reason: Recheck today's complaints.
- Problem is new.
- Symptoms are unchanged.

Signatures:

Dispatcher MedHost	EDMS	Smith, Justin, RN	RN js
Easterling, David, MD	MD dre	Bentrup, Edward, RN	RN eb1
Jaynes, Katherine, Scribe	Scribe kej		

Name: Aaliyah [REDACTED]

Print Time: 9/17/2017 12:24:27

MRN: 1116206
Account#: K20034078160
Page 3 of 3

Nurse's Notes

Name: Aaliyah [REDACTED]
Age: 3 yrs **Sex:** Female **DOB:** 10/01/2013
Arrival Date: 09/16/2017 **Time:** 08:42
Bed 10

Willis Knighton South

MRN: 1116206
Account#: K20034078160
Private MD: Allen, Scott

Presentation:

09/16 Method of Arrival: Ambulatory. js
 08:43 Preferred language for medical communication is English. Presenting complaint: Mother states: having a cough since Thursday and fever that started yesterday. Person Transporting: Parent. Transition of care: patient was not received from another setting of care. js
 08:47 Acuity: 4 - Semi-Urgent. js

Triage Assessment:

08:43 **General:** Appears well developed, well nourished, Behavior is cooperative, pleasant, Reports fever for 1-2 days. **Pain:** Faces, Legs, Activity, Cry, Consolability scale score is 0 out of 10. js

Historical:

- **Allergies:** No known drug Allergies;

Historical:

09:09 The history from nurses notes was reviewed and confirmed. Social history: The patient attends recently started, the patient is a minor. dre/kej
 09:24 Family history: Pertinent for: cancer, diabetes, hypertension, pertinent negatives; thyroid disease, No immediate family members are acutely ill. eb1
 Immunization history: Childhood immunizations up to date. Social history: The patient lives at home with family The patient/guardian denies using caffeine The patient speaks fluent English.

Screening:

08:43 **Abuse screen:** Unable to obtain physical abuse screening due to patient's inability to understand questions. js
Patient fall risk assessment; risks identified; None Intervention for positive screen: ED Physician notified, side rails up, parent/caregiver holding child, teaching provided regarding fall risk, with verbalized understanding.
Learning Barriers: the patient has a cognitive barrier to learning pt has autism.
Pedi Fall Risk None Identified.
Exposure risk/Travel Screening: None identified.

Assessment:

09:24 **General:** Appears in no apparent distress, well developed, well nourished, Behavior is appropriate for age, anxious, uncooperative, mobility; ambulates without assistance. **Neuro:** Level of Consciousness is alert, awake, obeys commands, Gait is steady, Speech is normal. **EENT:** Parent/caregiver reports the patient having nasal discharge that is watery for 3 day(s). **Respiratory:** Parent/caregiver reports the patient having cough that is non-productive, for 3 day(s). **Gastrointestinal:** Parent/caregiver reports the patient having anorexia. **Genitourinary:** Parent/caregiver reports the patient having normal urinary habits. Age appropriate behavior- Toddler (12 months to 4 yrs): autonomy-separate from parent, minimal language skills, fears pain, safety concerns. eb1

10:24 **Pain:** level that is acceptable is 0 out of 10 on a pain scale. eb1

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Height	Pain	Staff
08:43		135	28	98.4	100% on R/A	16.78 kg / 36 lbs 16 oz	36 in. (91.44 cm)	0/10	js

08:43 Body Mass Index 20.07 (16.78 kg, 91.44 cm) js

Vitals:

08:43 Acuity: 4 - Semi-Urgent. js

*Nurse's Notes Con't***Glasgow Coma Score:**

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
08:43	spontaneous(4)	oriented(5)	obeys commands(6)		15	js

ED Course:

08:42 Patient arrived in ED. ms2
 08:42 Patient moved to KIOSK. ms2
 08:43 Allen, Scott is Private Physician. js
 08:48 Patient moved to Waiting. js
 08:49 Patient moved to 10. eb1
 08:52 Bentrup, Edward, RN is Primary Nurse. eb1
 08:53 Easterling, David, MD is Attending Physician. dre
 09:24 Patient/caregiver encouraged to voice any concerns. Bed in low position. Call light in reach. Patient has correct armband on for positive identification. Adult with patient. Child being held by parent. eb1
 09:26 Patient moved to Radiology. drm
 09:26 Patient moved to 10. drm
 09:26 Chest 2 View *routine* Sent. drm
 10:23 No procedures done that require assistance. eb1

Administered Medications:

No medications were administered

Outcome:

10:03 Discharge ordered by MD. dre
 10:23 Discharged to home, ambulatory, with family. Discharge instructions given to Mother Grandmother. Instructed on discharge instructions, follow up and referral plans, medication usage, Demonstrated understanding of instructions, medications, Prescriptions given; None. No questions or concerns expressed to me at discharge. **Medication reconciliation form provided. Med Effects:** Patient recieved no medications during this visit. **Oxygen use:** Oxygen use not applicable. eb1
 10:24 Electronic medical record closed. eb1

Signatures:

Smith, Justin, RN	RN	js	Easterling, David, MD	MD	dre
Bentrup, Edward, RN	RN	eb1	Martinez, Dianna, RT	RT	drm
Scriptuser, MEDHOST		ms2	Jaynes, Katherine, Scribe		Scribe kej

Name: Aaliyah [REDACTED]

Print Time: 9/17/2017 12:24:26

MRN: 1116206
 Account#: K20034078160

Page 2 of 2

Willis-Knighton South
2510 Bert Kouns Industrial Loop
Shreveport, LA 71118

Patient Name: [REDACTED]
Adm No: K20034078160
DOB: 10/01/2013
Age: 3Y F
Corp ID: 000001116206

MRN: 1116206
Location: ER Patient - ERS-
Ord No: 90018
Hospital: WKS

Ordering Dr: DAVID RANDALL EASTERLING

CC:

Final Report

Admitting Diagnosis: COUGH FEVER
Reason For Exam: Cough, Fever
Procedure Date: 09/16/2017
Procedure: SXR - XR, chest 2 view

Interpretive Location: WKP
Accession Number: 3783078
CPT Code: 71020

IMPRESSION: Mild peribronchial cuffing is noted and can be seen with acute viral illness or in the setting of reactive airway disease.

RESULT:

Procedure: XR, chest 2 view

Clinical Information: Cough, Fever

Comparison: 8/28/2017

Findings:

Heart size and contour are within normal limits. The lungs are clear of infiltrate, mass lesion, or effusion. Mild peribronchial cuffing. No significant skeletal abnormality is seen.

Electronically Signed by: MICHAEL COLTER GATES M.D. on Sep 16 2017 9:55A

Techs: Dianna Martinez
Additional Staff:

Read by: MICHAEL COLTER GATES M.D. on Sep 16 2017 9:52A
Electronically Signed by: MICHAEL COLTER GATES M.D. on Sep 16 2017 9:55A

Printed: Sep 16 2017 9:59AM

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Plan Of Care Report

Generated from 08/17/2017 00:00 to 08/31/2017 23:59

Pt Name: [REDACTED] L MRN: 1116206
 Pt ID: 0101757329 Acct No: K20034078160
 DOB: 10/01/2013 Age/Sex: 3Y/F
 Adm DTime: 09/16/2017 08:51 Ath Dr: Easterling, David MD
 Nurs Sta: Willis-Knighton South Rm & Bed:
 Dx:
 Alrg: codeine, Fish Containing Products, Fish containing products

Plan of Care

No Plans Charted for Visit

Problems associated to Patient

Problem Name	Rank	Date Assigned	Date Closed	Assigned By	Closed By	Status
Problem Details	Value	Problem Details	Value	Problem Details	Value	
Breathing Pattern - Ineffective		08/28/2017 04:31		Meghan A Wallace, RN		Resolved
Status:						
Falls - Risk of		08/28/2017 04:31		Meghan A Wallace, RN		Resolved
Comment:		Status:				
Thermoregulation - Risk of, Impaired		08/28/2017 04:31		Meghan A Wallace, RN		Resolved
Comment:		Event:		Day Part:		
Severity:		Acute/Chronic:		Onset Date:		
Onset:		Status:				

Expected Outcomes

No Expected Outcomes Charted For Visit

Pt Name: HENDERSON, [REDACTED] L
 Rm/ Bed:

MRN: 1116206
 Page 1 of 1

Plan Of Care Report
 ORE_0146_DSCH_NBR_v1.rpt v1.00
 Printed By :Workflow
 Printed On: 17-Sep-17 10:47

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ALLERGY REPORT

Pt Name: [REDACTED] L MRN: 1116206
Pt ID: 0101757329 Acct No: K20034078160
DOB: 10/01/2013 Age/Sex: 3Y/F
Adm DTime: 09/16/2017 08:51 Atn Dr: Easterling, David MD
Nurs Sta: Willis-Knighton South Rm & Bed:
Dx:
Alerg: codeine, Fish Containing Products, Fish containing products

Alerg Type	Alerg Name	Onset	Reaction	Severity	Comment
Drug	codeine	7/14/2017	Shortness of Breath	Severe	"Took codeine yesterday. Started wheezing, couldn't breathe like she was having an asthma attack"
Drug	Fish Containing Products	05/2017	Anaphylaxis	Severe	Patient severely allergic. Reaction when touches seafood
Food	Fish containing products	05/2017	Anaphylaxis	Severe	Patient severely allergic. Reaction when touches seafood

Pt Name: [REDACTED] L
Rm/ Bed:

MRN: 1116206
Page 1 of 1

Allergy Report
ORE_0109_DSCH_NBR.rpt v1.00
Printed By :Workflow
Printed On: 17-Sep-17 10:47

RUN DATE: 09/16/17
RUN TIME: 0852
RUN USER: ALEXAJ.AM

Willis Knighton South *ADMISSIONS
INTERDISCIPLINARY ALLERGY SOURCE DOCUMENT

PAGE 1

Name: [REDACTED] L DOB: 10/01/13 Age: 3Y 11M
Rm/Bd: Serv/Loen: ERS Status: ER Sex: F
Unit#: K000629604 Account#: K20034078160 KPI#: 000000001116206

Last Update/
Acknowledgement:

Interdisciplinary Assessment (Free Text), historical data:

Allergy1-Med/Contact: NKDA	11/04/16 - 2201
Allergy2-Med/Contact: NKDA	11/04/16 - 2201
Food Allergies-Intol: NKFA	11/04/16 - 2201
Latex Allergy (Y/N): N	11/04/16 - 2201

Pharmacy Allergy List (Coded Allergies), historical data:
(Duplicate names represent coding within (3) categories:
Ingredient, Generic and Class allergy codes.)

11/06/16

NO KNOWN DRUG ALLERGIES, NO KNOWN FOOD ALLERGIES, NO KNOWN LATEX ALLERGY

Interdisciplinary Allergy Source Document is a Permanent Part of
the Patient's Medical Record



HENDERSON [REDACTED] L
10/01/13 3Y 11M
Easterling, David R
K20034078160 09/16/17

Willis Knighton South and Center for Womens Health

Willis Knighton South
2510 Bert Kouns Industrial Loop
Shreveport, LA 71118
318-212-5500



Discharge Instructions for:

Arrival Date:

09/16/2017 08:42

Care Complete Time:

09/16/2017 10:03



10/01/13 3Y IIM
Easterling, David R
K20034078160 09/16/17

Thank you for choosing Willis Knighton South for your care today. The examination and treatment you have received in the Emergency Department today have been rendered on an emergency basis only and are not intended to be a substitute for an effort to provide complete medical care. You should contact your follow-up physician as it is important that you let him or her check you and report any new or remaining problems since it is impossible to recognize and treat all elements of an injury or illness in a single emergency care center visit.

Care provided by: Easterling, David, MD

Diagnosis: .URI Acute upper respiratory infection, unspecified

DISCHARGE INSTRUCTIONS	FORMS
Upper Respiratory Infection, Pediatric	None
FOLLOW UP INSTRUCTIONS	PRESCRIPTIONS
Private Physician When: Next week; Reason: Recheck today's complaints	None
SPECIAL NOTES	
None	

I hereby acknowledge that I have received and understand the above instructions and prescriptions (if any).

Aaliyah Henderson

MRN # 1116206

ED Physician or Nurse

X-RAYS and LAB TESTS:

If you had x-rays today they were read by the emergency physician. Your x-rays will also be read by a radiologist within 24 hours. If you had a culture done it will take 24 to 72 hours to get the results. If there is a change in the x-ray diagnosis or a positive culture, we will contact you. Please verify your current phone number prior to discharge at the check out desk.

MEDICATIONS:

If you received a prescription for medication(s) today, it is important that when you fill this you let the pharmacist know all the other medications that you are on and any allergies you might have. It is also important that you notify your follow-up physician of all your medications including the prescriptions you may receive today.

Chart Copy

FOLLOW UP INSTRUCTIONS

Private Physician

When: Next week

Reason: Recheck today's complaints

TESTS AND PROCEDURES

Labs

None

Rad

Chest 2 View "routine"

Procedures

None

Other

Call X-Ray Tech



AALIYAH L
10/01/13 3Y 11M
Easterling, David R
K20034078160 09/15/17



ASSIGNMENT OF BENEFITS

1. Hospital Care Consent: I/we consent to hospital services, treatment and diagnostic procedures by the hospital as may be deemed necessary or advisable by my physician and/or consultants selected by my physician. The consent to hospital care includes permission for x-ray examinations, laboratory procedures, I.V. treatments, hepatitis test administration of blood and blood products, injections, medications, recording, filming or video monitoring for internal purposes only, and hospital services rendered the patient under the general and special instruction of doctors. The patient acknowledges responsibility for any or all of these procedures. It is the hospital policy that the patient has the opportunity to discuss surgery and procedures with the patient's doctor before hand. The patient has the right to consent to surgery and procedures. Except in emergencies or unusual circumstances, the hospital does not allow its facilities to be used without this discussion and patient's consent. I voluntarily give my consent to hospital care and accept the condition of hospitalization listed.

2. Authorizations for Release of Information: The employees and agents of this hospital and copy services and electronic claims processing services under contract with this hospital and any third party billing agents for this hospital or any of its staff physicians involved with patient care are given permission to release any and all information relating to the patient, including but not limited to the medical record of the patient's hospitalization, to another healthcare provider if the patient was transferred to that facility from this hospital and to any and all insurance companies or other third-party paying or obligated to pay, in whole or in part, the charges incurred by the patient in this hospital; and they are also given permission to release the above described information to any agent or firm working for or with the above described insurance companies or other third-party payors for the purpose of performing pre-certification, concurrent and/or retrospective review and/or other utilization review of any kind.

3. Valuables: I understand and acknowledge that the hospital assumes no responsibility for personal possessions including cash, jewelry, bridgework, eyeglasses or any other personal possession which I choose to keep in my room. I have been advised that such valuables should be placed in the care of my family or deposited in the hospital vault located in the Business Office.

4. Safety Code for Hospital: Safety Codes for hospitals issued by the National Fire Protection Association prevent the use in the hospital of any electrical equipment or accessories until they have been safety checked by the hospital's electrical engineer. Exceptions to this rule are hair and blow dryers, curling irons, hot rollers, radios, clocks, electric razors, shavers, contact lens sterilizers, electric toothbrushes and calculators.

5. Payment Guaranty and Assignment of Insurance Benefits: I, the undersigned patient, guardian, and/or guarantor (hereinafter "Debtor") hereby promise to pay in full Willis-Knighton Health System (WKHS) customary charges for the goods and services rendered to the patient identified on the reverse side hereof during this period of hospitalization (hereinafter "Indebtedness"). Debtor acknowledges and agrees that, unless waived in full by WKHS as set forth below, the Indebtedness accruing during this hospitalization is due and payable in such amounts and at such times during this hospitalization as WKHS may, in its sole discretion, determine, that the entire Indebtedness is due and payable in full at discharge. I acknowledge that, upon proof of acceptable insurance coverage, WKHS, in its sole discretion, may reduce the amount of indebtedness due and payable during this hospitalizations and the balance due at discharge. In such event, I understand that all deductibles, co-insurance, non-covered charges and other items not paid by insurance or other third-party payors shall be due and payable during this period of hospitalization and upon discharge as set forth hereinabove. I acknowledge and agree that in the event that WKHS, in its sole discretion, accepts proof of insurance coverage, claims for payment for benefits will be filed on behalf of the Debtor and/or the insured and that these benefits will be considered by WKHS in determining the amounts due as set forth hereinabove. I understand and agree that WKHS will accept payments from third-party payors and insurers on behalf of the Debtor and apply such payment to the indebtedness to the extent that they are received. I acknowledge and agree that the filing of such insurance and other third-party claims is performed as a service by WKHS and in no way relieves me of the obligation to pay the Indebtedness as agreed herein above.

Patient hereby appoints WKMC as Patient's authorized representative to file any necessary claim appeal(s) on Patient's behalf. In consideration for this appointment, WKMC agrees only to collect only applicable copayments, deductibles, and coinsurance for covered benefits from the Patient and waives any right to collect any other payments related to those covered benefits from the Patient.

Debtor hereby absolutely assigns to WKHS all insurance benefits on all policies of insurance under which Debtor is an insured, whether hospital, medical, liability or other insurance, and also hereby absolutely assigns to WKHS the proceeds of any judgment or settlement of any claim against any third party and any and all other amounts which may be determined in any manner to be payable to Debtor in connection with any injury suffered by the patient which gives rise to the Indebtedness incurred during this period of treatment. I hereby authorize WKHS to obtain any and all information related to such injuries, including, but not limited to, accident reports and agree to cooperate with WKHS in connection with the procurement of any information or documents WKHS deems in its sole discretion, necessary or appropriate in connection with the assignment made pursuant to this paragraph. I hereby authorize and direct that all such payments and proceeds shall be made directly to WKHS under the terms of this assignment. Any receipts from WKHS shall be applied towards Indebtedness but such application shall not relieve the Debtor from the Debtor's obligation to pay any remaining portion to the Indebtedness. Debtor acknowledges and agrees that, to the extent that the Indebtedness has not been satisfied by such receipts, that portion of the Indebtedness for which payment has been deferred pursuant to the preceding paragraph shall be due and payable in full on the thirtieth day following the date of service. In the event that WKHS receives proceeds and/or payments in excess of the Indebtedness, WKHS may apply such excess payment to any outstanding Indebtedness of Debtor to WKHS arising out of any other period(s) of treatment as well as any attorneys' fees and expenses for which Debtor may be liable hereunder. In the event that all Indebtedness has been paid

Admission Date: 09/16/17

Admission Time: 0851



AM0005



10/01/13 3Y F
Easterling, David R M.D.
K20034078180 09/16/17



ASSIGNMENT OF BENEFITS

in full, then WKHS will refund the Debtor any such excess payment. Notwithstanding anything herein to the contrary, the assignments made hereby shall remain in full force and effect until the entire Indebtedness and any and all attorneys' fees and expenses for which Debtor may be liable have been paid in full. In the event that the Indebtedness is not paid when and as due as determined by WKHS hereunder, and the Indebtedness is placed in the hands of an attorney for purposes of collection, Debtor agrees to pay reasonable attorneys' fees, which are hereby acknowledged to be one-third (1/3) of the amount of the Indebtedness at the time the matter is placed in the hands of an attorney, plus any and all court costs and other expenses incurred in connection with the collection of the Indebtedness.

Financial assistance is available to all patients who meet the requirements of our charity care policy. Patients are encouraged to contact the Business Office if they have any concerns or need assistance in paying their bills. Our charity care policy is limited to hospital charges and does not include physician, anesthesiologist or professional charges that are not billed by the hospital. In addition, financial assistance is not offered for cosmetic, elective, experimental or other treatments and all hospital services must be ordered by your physician.

6. Assignment to Physicians: I understand that my physician as well as other physicians who treat me or otherwise involved in my care while a patient at the hospital are not employees or agents of the hospital and the hospital is not responsible for their actions. I further understand that my physician or other physicians will send me a separate bill for their services, in addition to the hospital bill. I hereby assign to all physicians who treat me the benefits due to me for these services covering medical and/or surgical expenses. I agree that should be the amount be insufficient to cover the entire medical/surgical expense, I will be responsible to said physicians for payment of the entire bill.

7. Medicare Consent: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act (SSA) is correct. I authorize Willis-Knighton Health System (WKHS) to provide (SSA) or its intermediaries with access to my medical/hospital record for the purpose of processing the Medicare claim for this or a related Medicare claim. I further request that WKHS provide such copies thereof as may be requested. Copies may be made by WKHS or its agents or contractors providing copy service and electronic claims processing services and said third party billing agents for hospital and staff physicians involved with patient care.

8. Champus/Medicare Notice: Champus/Medicare will not pay for private rooms unless medical justified, personal convenience items, diagnostic admissions or test or hospital stays not medically necessary. My signature below acknowledges my receipt of this information regarding Champus/Medicare from the hospital on the date indicated.

9. Willis-Knighton Health System (and our Medical Staff) will use and disclose your personal health information to treat you, to receive payment for the care we provide and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website and have copies available for distribution. I acknowledge that I have received a copy of the Notice of Privacy Practices.

This form has been fully explained to me. My signature reflects my understanding of the information contained herein. I further understand and acknowledge that all references to myself as the patient shall be deemed to apply as if rewritten in their entirety to a dependent for whom I am responsible for and/or who is unable to consent on their behalf for reasons indicated below.

I acknowledge that I have been informed of my rights and obligations as a patient.

<u>[Signature]</u>	<u>9-16-17</u>	<u>[Signature]</u>	<u>9/16/17</u>	<u>[Signature]</u>	<u>9/16/17</u>
Signature of Patient/Guardian	Date/Time	Guarantor	Date/Time	Witness	Date/Time
<u>Wendy Alexander</u>		<u>[Signature]</u>		<u>[Signature]</u>	
Print Name		Print Name		Print Name	

If Patient/Guarantor is unable to sign, I, _____, do hereby state that I have been given the authority to sign for

_____, either expressed or implied and that he or she is fully aware of this authority.

_____ Signature of Authorized Party	_____ Authorized Party's Relationship to the Patient	_____ Date/Time	_____ Witness	_____ Date/Time
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Admission Date: 09/16/17
Admission Time: 0851



AM0005



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10/01/13 3Y F
Easterling, David R M.D.
K20034078160 09/16/17

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WK South Hospital
K20034006872

S5E1S5517A
Sharon N Tran, M.D.

Report Type: SUMM

ADMITTED: 08/28/2017
DISCHARGED: 08/30/2017

HOSPITAL COURSE: Alliyah is a 3-year-old who was admitted to the Pediatric service for status asthmaticus. She has a past medical history significant for asthma and autism and has had several admissions for asthma. She presented to the emergency room with labored breathing and wheezing. Her mom reports that she developed runny nose and cough two days prior to admission. The day prior to admission she began wheezing and mom was given albuterol nebulizations at home. However, she worsened and became short of breath. In the emergency room she had a T-max of 100.8 and was noted to be tachypneic with respirations in the 40s and oxygen saturation of 84% on room air. She received albuterol nebulizations and magnesium sulfate in the emergency room and was subsequently admitted for further care. Her workup in the emergency room included a CBC which showed a white count of 15,000. Chemistries were unremarkable. Blood culture was done which was negative at two days and a chest x-ray was also done which did not show any infiltrates. During her admission, she received albuterol and Atrovent nebulizations, IV fluids, and IV steroids. She improved clinically and her respiratory distress and hypoxia resolved. She was weaned to room air without any issues. She was also seen by the asthma task force and her mom was provided asthma education and was also provided with an aero chamber and instructions on how to use it. She was discharged home on 8/30/17 on albuterol nebulizations 2.5 mg q 4 as needed for wheezing and Orapred 15 mg p.o. twice a day for 3 days. She will follow-up with her primary care physician and also has a followup appointment with Pediatric Pulmonology, Dr. Jones, that is scheduled.

DISCHARGE DIAGNOSES:

1. STATUS ASTHMATICUS.
2. UPPER RESPIRATORY INFECTION.
3. AUTISM.

Sharon N Tran, M.D.

PHYS: 002944
DICT DATE: 08/30/2017 02:09 P
TRANS DATE: 09/04/2017 08:42 A

WK South Hospital
K20034006872

S5E1S5517A
Sharon N Tran, M.D.

Report Type: SUMM

BY: bb
DISCHARGE SUMMARY
JOB #2346592

**Electronically Signed by: TRAN, SHARON NHU M.D. on 06-Sep-2017
11:03:38 -05:00**



WILLIS-KNIGHTON HEALTH SYSTEM

Pediatric Hospitalist History and Physical

Patient Name: _____ Date: 8/20/12 Time: _____

PCP: LSU Source of Information: MM

Chief Complaint: Labored breathing

History of Present Illness: _____

3 y/o female is PMH sig for Asthma, Autism predicted to LKS ER
 is labored breathing & wheezing. Mom reports pt developed Rung nose
 & cough 2 days ago. Yesterday she began wheezing & mom was giving
 Alb nebs at home. But pt worsened & became sick.
 She was taken to ER for eval. @ Home Max 10.8 at home
 In ER, pt tachypneic RR: 40s O₂ sat: 84% on RA
 Pt received humid Alb nebs & Mg sulfate x1 & was admitted
 for further care. PVD @ discharge

Past Medical/Birth History: ☐ Unremarkable ☒ Other Asthma is same admit - last 7/20/17,
Hx of prematurity 27 wks GA, stayed in NICU @ UH, Autism

Past Surgical History: Ø

Allergies: ☐ NKDA ☒ Other Codine

Immunizations: ☒ UTD ☐ Other _____

Family History: ☒ Noncontributory ☐ Other _____

Social History: ☒ Lives at home with parents MM ☒ Attends school ECRESE

☐ Other _____

Home Medications: Albuterol prn

(32) (31)
 1



HP0005



HENDERSON, AALIYAH L
 10/01/13 3Y 10M
 Tran, Sharon N.M.D. S5517
 K20034006872 08/28/17



WILLIS-KNIGHTON HEALTH SYSTEM

Pediatric Hospitalist History and Physical continued

General: ☐ None ☒ Fever ☒ Decreased appetite/oral intake ☐ Decreased activity ☐ Fussy ☐ Other _____HEENT: ☐ None ☐ Head injury ☐ Red/Swollen eyes ☐ Eye d/c ☒ Runny nose ☐ Congestion ☐ Earache ☐ Ear d/c☐ Sore throat ☐ Other _____Cardiovascular: ☒ None ☐ Cyanosis ☐ Chest pain _____Respiratory: ☐ None ☒ Cough ☒ SOB ☒ Wheeze ☐ Other _____GI: ☒ None ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Abd pain ☐ Bloody stools ☐ Other _____Hematology: ☒ None ☐ Easy bruising ☐ Epistaxis ☐ Other _____Neuro: ☒ None ☐ Headache ☐ Syncope ☐ Seizures ☐ LOC ☐ Other _____GU: ☒ None ☐ Decreased urine ☐ Dysuria ☐ Discharge ☐ Other _____Physical Exam: ☒ 10 systems reviewed and per History of Present Illness otherwise negativeVitals: Temp 99.9 HR 140 RR 52 O2 sat 94% Wt 16.7 KgGeneral: ☒ Well-hydrated ☒ WN ☒ NAD ☒ Nontoxic ☐ Remarks _____HEENT: ☒ Normocephalic atraumatic ☐ Anterior fontanelle open & flat ☒ PERRL ☒ Conjunctiva clear☒ No rhinorrhea/congestion ☐ Nasal flaring ☐ Tympanic membranes normal bil ☒ Oral mucosa moist ☒ Pharynx normal☐ Remarks ② m. c. t. m. c.Neck: ☒ Normal ☒ Supple ☒ No rigidity ☐ Adenopathy ☐ Masses ☐ Jugular vein distention☐ Remarks _____Heart: ☐ Normal ☒ S1S2 ☐ RRR ☐ Murmur ☐ Remarks _____Lungs: ☐ Normal ☐ CTA bil ☐ Unlabored Air movement: ☐ good ☐ fair ☐ poor ☒ Wheeze (end expiratory/inspiratory)☐ Remarks ② ventilation b/c, tachypneicAbdomen: ☒ Normal ☒ Soft ☒ Non-tender ☒ Non-distended ☒ Normal active bowel sounds ☐ Hepatosplenomegaly☐ Masses ☐ Remarks _____Extremities: ☒ Normal ☐ Cyanosis ☒ Capillary refill less than 2 seconds ☐ Edema ☐ _____ Pulses☐ Remarks _____Musculoskeletal: ☒ Normal ☐ Joints full ROM ☐ Pain ☐ Contractures ☐ Weakness ☐ Remarks _____Skin: ☒ Normal ☐ Rash ☐ Remarks _____Neuro: ☒ Normal/nonfocal ☒ Awake ☒ Alert ☐ Oriented ☐ Times 3 ☐ Irritable ☐ Sedated ☐ CN 2-12 intact☐ Remarks _____GU: ☒ Normal male/female genitalia Testes descended: ☐ Right ☐ Left ☐ Deferred☐ Remarks _____

HP0005

HENDERSON, AALIYAH L
10/01/13 3Y 10M
Tran, Sharon N M.D. 3517
K20034006872 01/28/



Pediatric Hospitalist History and Physical continued

LAB: ☒ Reviewed ☐ Abnormals

144 | 106 | 9
4.51 | 23 | 0.45 | 125

Ca 9.5
Alb AstAlt
Alk/Phos
T/Bili

11
15.1
34.1

Segs 80
Bands
Lymphs 11

☒ CXR infectious ☐ Cultures

Other:

Plan:

- ☒ See orders ☒ Continue medical management ☒ Follow labs ☒ O2, Respiratory Therapy
☒ IV Fluids Discussed assessment & plan with ☐ Patient ☒ Family
☐ IV antibiotics:

☐ Consults:

☐ Remarks: 3 y/o E status asthmaticus, URI, acute resp distress, hypoxia.

- ☐ Extended time spent counseling patient and family
☐ Total time spent _____ minutes.
☐ Face to face _____ minutes.

Clinically stable. On Albuterol/
Atenolol nebs, IV steroids, IV
Acute education by asthma
nurse.

[Signature] 6/20/12 2pm
Physician Signature Date/Time

- ☒ Sharon Tran, M.D. (2944) ☐ Greg Oji, M.D. (2977)
☐ Craig Chu, MD (3101) ☐ Anna Craig, MD (3110)



HP0005



AALIYAH
10/01/13 3Y 10M
Tran, Sharon N M.D. 5517
K20034006872 01/28/20

Nurse's Notes

Name: Aaliyah
Age: 3 yrs Sex: Female DOB: 10/01/2013
Arrival Date: 08/28/2017 Time: 01:18
Bed 12

Willis Knighton South

MRN: 1116206
Account#: K20034006872
Private MD: LSU/UH, KidMed clinic

Presentation:

08/28 Preferred language for medical communication is English. Presenting complaint: Mother states: Her nose
01:18 started running Saturday and now she's wheezing, I don't know what's down in her lungs, but she's got fever
and I gave her Motrin and a treatment at 0000. Person Transporting: Parent. Transition of care: patient was
not received from another setting of care.
01:22 Acuity: 2 - Emergent.
01:24 Method of Arrival: Ambulatory.

Triage Assessment:

01:18 **General:** Appears well developed, well nourished, uncomfortable, Behavior is appropriate for age,
uncooperative. **Pain:** Denies pain.

Historical:

- **Allergies:** Codeine;
- **Home Meds:**
1. Albuterol Nebulizer
- **PMHx:** Asthma
- **PSHx:** None

Historical:

01:24 Family history: No immediate family members
are acutely ill. Immunization history:
Childhood immunizations up to date.
01:34 The history from nurses notes was reviewed
and confirmed. Family history: Father has/had
no known health problems. Mother has/had
hypertension. Social history: The patient lives
at home The patient speaks fluent English, the
patient is a minor.

Screening:

01:18 **Abuse screen:**
Denies threats or abuse. Denies injuries from
another. there are no obvious signs of child
abuse.
Patient fall risk assessment;
risks identified; None.
Learning Barriers:
No barriers to teaching and learning identified.
ready and willing to learn, caregiver ready and
willing to learn.
Pedi Fall Risk
None Identified.
Exposure risk/Travel Screening:
None identified.

Assessment:

01:25 **Pain:** Denies pain. level that is acceptable is 0 out of 10 on a pain scale. **General:** Appears well developed,
well nourished, distressed, uncomfortable, Behavior is appropriate for age, uncooperative. **Neuro:** Level of
Consciousness is alert, awake, Moves all extremities. Full function. **Cardiovascular:** Capillary refill < 3
seconds is brisk in bilateral fingers. **Respiratory:** Respiratory effort is even, labored, with retractions,
Respiratory pattern is symmetrical, tachypnea Airway is patent Breath sounds with wheezes upon
exhalation. **Dermatologic:** Skin is intact, is healthy with good turgor, Skin is normal.

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Pain	Staff
01:18		167	36	97.6	84% on R/A	16.78 kg / 36 lbs 16 oz		hk1
01:26		170	40		99% 15%			hk1
02:07		172	35		100% on Non- rebreather mask			hk1
02:49		149	31		99% on 3 lpm NC			hk1
03:34		151	30	97.2(A)	98% on R/A			hk1

Vitals:

01:18 Acuity: 2 - Emergent.

*Nurse's Notes Con't***Glasgow Coma Score:**

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
01:18	spontaneous(4)	oriented(5)	obeys commands(6)		15	hk1

ED Course:

01:18 Patient arrived in ED. ms2
 01:18 Patient moved to KIOSK. ms2
 01:22 Kirkikis, Helen, RN is Primary Nurse. hk1
 01:22 Patient moved to 12. hk1
 01:24 LSU/UH, KidMed clinic is Private Physician. hk1
 01:24 Patient placed in exam room on oxygen on pulse oximetry. hk1
 01:26 O2 via face mask @ 15L/min. hk1
 01:30 Critical Med Co-Sign: SOLU-Medrol 2 mg/kg (32 mg) IVP, dosage verified by Jennifer Morrow, RN. jm15
 01:34 Brandhurst, Roy, MD is Attending Physician. rb
 01:35 Inserted saline lock IV, 22 gauge in right antecubital area and blood collected. by Jenn, RN. hk1
 01:35 Blood collected; (by ED staff). specimen labeled in the presence of the patient Sent per order to lab. blood cultures sent to lab. jm15
 01:46 Critical Med Co-Sign: Albuterol 2 unit doses inhalation, dosage verified by Amanda, RN. aka
 02:59 CALLED DR TRAN. ck3
 03:04 DR TRAN RETURNED CALL. ck3
 03:06 Tran, Sharon, MD is Hospitalizing Provider. rb
 03:07 Waiting for Bed Assignment. rb
 03:26 Waiting for Bed Assignment. ck3
 03:38 attempted to give report to 5E; unavailable at this time. Will call back in 15 minutes. hk1
 03:46 Patient/caregiver encouraged to voice any concerns. Side rails up X 1. Bed in low position. Patient has correct armband on for positive identification. Adult with patient. hk1
 03:46 No procedures done that require assistance. hk1

Administered Medications:

Time	Drug & Dose <i>Dispensable & Quantity</i>	Volume	Route	Rate	Infused Over	Site	Delivery	Staff
01:26	DuoNeb 1 unit dose		Inhalation		15 mins			hk1
01:35	SOLU-Medrol 2 mg/kg		IVP		2 mins	right antecubital		hk1
01:47	Albuterol 5 mg		Inhalation					jm15
02:07	Magnesium Sulfate 850 mg		IVPB		33 mins	right antecubital		hk1

Outcome:

03:07 Decision to Hospitalize by Provider. rb
 03:45 Moved to Pediatrics Room # 5517, accompanied by tech, carried by parent with chart. Instructed on admit to floor admission process Demonstrated understanding of instructions, Prescriptions given; None. No questions or concerns expressed to me at discharge. **Medication reconciliation form provided. Med Effects:** Effects of administered medications were addressed. **Oxygen use:** Oxygen used on this visit. hk1

Name: Aaliyah [REDACTED]

MRN: 1116206
Account#: K20034006872

Print Time: 8/29/2017 06:16:17

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Nurse's Notes Con't

04:01 Electronic medical record closed.

hk1

Signatures:

Brandhurst, Roy, MD	MD	rb	Scriptuser, MEDHOST	ms2
Morrow, Jennifer, RN	RN	jm15	Kemp, Christine, ED Tech	ED Tech ck3
Kirkikis, Helen, RN	RN	hk1	Rose, Amanda, RN	RN aca

Name: Aaliyah [REDACTED]

Print Time: 8/29/2017 06:16:17

MRN: 1116206
Account#: K20034006872
Page 3 of 3

Physician Documentation

Willis Knighton South

Name: Aaliyah [REDACTED]
Age: 3 yrs Sex: Female DOB: 10/01/2013
Arrival Date: 08/28/2017 Time: 01:18
Bed 12

MRN: 1116206
Account#: K20034006872
Private MD: LSU/UH, KidMed clinic

HPI:

08/28 This 3 yrs old Black/African Am Female presents to ED via Ambulatory with complaints of **Breathing** rb
01:34 **Difficulty**
01:34 The patient presents to the emergency department with congestion, with nasal discharge, that is clear, that is mild, cough, that is intermittent, described as moderate, with no sputum, fever, that was measured at 102 degrees Fahrenheit, with an emergency department temperature of 97.6 degrees Fahrenheit, rhinorrhea, wheezing. Onset: The symptoms/episode began/occurred acutely, 2 day(s) ago, and became worse this morning. Associated signs and symptoms: Pertinent positives: congestion, cough, fever, nasal discharge, shortness of breath, wheezing, Pertinent negatives: abdominal pain, body aches, constipation, diarrhea, dysuria, earache, headache, sore throat, vomiting. Modifying factors: The patient symptoms are alleviated by nothing, the patient symptoms are aggravated by coughing. Treatment prior to arrival: albuterol nebulizer, ibuprofen. The patient has experienced similar episodes in the past, several times. last admitted to hospital in July for asthma. Has been on steroids previously..

Historical:

- **Allergies:** Codeine;
- **Home Meds:**
 1. Albuterol Nebulizer
- **PMHx:** Asthma
- **PSHx:** None

Historical:

01:24 Family history: No immediate family members are acutely ill. Immunization history: Childhood immunizations up to date. hk1
01:34 The history from nurses notes was reviewed and confirmed. Family history: Father has/had no known health problems. Mother has/had hypertension. Social history: The patient lives at home The patient speaks fluent English, the patient is a minor. rb

ROS:

01:34 **Eyes:** Negative for injury, pain, redness, and discharge. **Neck:** Negative for injury, pain, and swelling, rb
Cardiovascular: Negative for Chest pain, palpitations, and edema. **Abdomen/GI:** Negative for abdominal pain, nausea, vomiting, diarrhea, and constipation, **Back:** Negative for injury and pain, **GU:** negative for foul smelling urine, painful urination or blood in urine. **MS/Extremity:** Negative for injury and deformity, or swelling. **Skin:** Negative for injury, rash, and discoloration, petechia or purpura. **Constitutional:** Positive for coughing, fever, shortness of breath, Negative for chills, fatigue, fussiness, acute pain. **ENT:** Positive for rhinorrhea, sinus congestion, Negative for ear pain, sore throat. **Respiratory:** Positive for cough, with no reported sputum, shortness of breath, wheezing. **Neuro:** Negative for altered mental status, headache, seizure activity, weakness. ROS as in the HPI, and all other systems were reviewed negative, or noncontributory.

Exam:

01:34 rb
Head/Face: Normocephalic, atraumatic.
Eyes: Pupils equal round and reactive to light, extra-ocular motions intact. Lids and lashes normal. Conjunctiva and sclera are non-icteric and not injected. Cornea within normal limits. Periorbital areas with no swelling, redness, or edema.
ENT: Nares patent. No nasal discharge, no septal abnormalities noted. Tympanic membranes are normal and external auditory canals are clear. Oropharynx with no redness, swelling, or masses, exudates, or evidence of obstruction, uvula midline. Mucous membrane moist/pink.
Neck: Trachea midline, no thyromegaly or masses palpated, and no cervical lymphadenopathy. Supple, full range of motion without nuchal rigidity, or vertebral point tenderness. No Meningismus.
Cardiovascular: Regular rate and rhythm with a normal S1 and S2. No gallops, murmurs, or rubs. Normal

Physician Documentation Con't.

PMI, no JVD. No pulse deficits.

Abdomen/GI: Soft, non-tender with normal bowel sounds. No distension, tympany or bruits. No guarding, rebound or rigidity. No palpable masses or evidence of tenderness with thorough palpation. No hernia. No splenomegaly. No hepatomegaly.

Back: No spinal tenderness. No costovertebral tenderness. Full range of motion.

Skin: Warm and dry with excellent turgor. capillary refill <2 seconds. No cyanosis, pallor, rash or edema.

MS/ Extremity: Pulses equal, no cyanosis. Neurovascular intact. Full, normal range of motion.

Psych: Behavior, mood, response, and affect are appropriate for age.

Female GU: No CVA tenderness or bladder tenderness or distension.

Constitutional: The patient appears Blood pressure, pulse, respirations and temperature noted. awake, alert, well developed, non-diaphoretic, non-toxic, in distress, that is moderate, afebrile, short of breath.

Respiratory: moderate respiratory distress is noted, Respirations: labored breathing, that is moderate; accessory muscle usage, that is mild, nasal flaring, that is moderate, shallow respirations, that is moderate, tachypnea, that is moderate, Breath sounds: wheezing, that is severe, is heard diffusely.

Neuro: Orientation: appropriate for stated age, Mentation: appropriate for stated age, Motor: is normal, moves all fours, strength is 5/5 in all extremities, Sensation: is normal.

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Pain	Staff
01:18		167	36	97.6	84% on R/A	16.78 kg / 36 lbs 16 oz		hk1
01:26		170	40		99% 15%			hk1
02:07		172	35		100% on Non-rebreather mask			hk1
02:49		149	31		99% on 3 lpm NC			hk1
03:34		151	30	97.2(A)	98% on R/A			hk1

Glasgow Coma Score:

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
01:18	spontaneous(4)	oriented(5)	obeys commands(6)		15	hk1

MDM:

01:34 Patient medically screened.

rb

01:34

rb

Differential diagnosis: bacterial infection, bronchitis, fever, pneumonia URI, viral infection, asthma exacerbation.

Data reviewed: vital signs, nurses notes, lab test result(s), radiologic studies, and as a result, I will admit patient, initiate a consult, order radiologic study(s), order laboratory test(s) administer steroids, administer nebulizer.

Counseling: I had a detailed discussion with the patient and/or guardian regarding: the historical points, exam findings, and any diagnostic results supporting the discharge/admit diagnosis, lab results, radiology results, the need for further work-up and treatment in the hospital.

Admission orders: after a detailed discussion of the patient's condition and case, the admit orders are written by me.

02:08

rb

ED course: Reassessed. Much improved. No retractions or nasal flaring. Still wheezing. Will continue supportive care and admit for further care.

02:59

rb

Physician consultation: Dr. Sharon Tran MD was called at 03:00, was contacted at 03:00, regarding admission, patient's condition.

Order	Status	Time	By	For
-------	--------	------	----	-----

Name: Aaliyah [REDACTED]

MRN: 1116206

Account#: K20034006872

Print Time: 8/29/2017 06:16:19

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Physician Documentation Con't.

DuoNeb 1 unit dose Inhalation once	Ordered	08/28/17 01:26	hk1	ep
	Administered	08/28/17 01:26	hk1	
Notes:	Order Method: Verbal - Read back			
	Sign off: Brandhurst, Roy, MD 08/28/17 01:39			
Drug alert over ride reasons: MD discretion				
08/28/17 01:26 Administered: DuoNeb 1 unit dose Inhalation over 15 mins hk1				
Order	Status	Time	By	For
SOLU-Medrol 2 mg/kg IVP once	Ordered	08/28/17 01:29	hk1	ep
	Administered	08/28/17 01:35	hk1	
Notes:	Order Method: Verbal - Read back			
	Sign off: Brandhurst, Roy, MD 08/28/17 01:39			
08/28/17 01:35 Administered: SOLU-Medrol 2 mg/kg IVP in right antecubital over 2 mins hk1				
Order	Status	Time	By	For
CBC With Diff	Ordered	08/28/17 01:35	hk1	ep
	Returned	08/28/17 02:48	Dispatcher MedHost	
Notes:	Order Method: Verbal - Read back			
	Sign off: Brandhurst, Roy, MD 08/28/17 01:39			
Comments: (OEMICCOM):				
Ordering Location: ERSPC100.1				
Priority LAB: Stat				
Quantity 1: 1				
COLLECTED BY NURSE? (Y/N) (OELBCBN): No				
Order	Status	Time	By	For
Chem 8	Ordered	08/28/17 01:35	hk1	ep
	Reviewed	08/28/17 02:43	Roy Brandhurst	
Notes:	Order Method: Verbal - Read back			
	Sign off: Brandhurst, Roy, MD 08/28/17 01:39			
Interpretation: Normal except: Glucose 125.				
Comments: (OEMICCOM):				
Ordering Location: ERSPC100.1				
Priority LAB: Stat				
Quantity 1: 1				
COLLECTED BY NURSE? (Y/N) (OELBCBN): No				
Order	Status	Time	By	For
Chest 1 View	Ordered	08/28/17 01:35	hk1	ep
	Reviewed	08/28/17 01:56	Roy Brandhurst	
Notes: Bed Name: 12	Order Method: Verbal - Read back			
	Sign off: Brandhurst, Roy, MD 08/28/17 01:39			
Interpretation: No acute disease.				
WEIGHT?: (OERDWEIGHT): 16.78				
ER EXAM ROOM/BED: (OERDERRMBD): 12				
Is the patient able to bear weight? (OERDBEARWT):				
Is the patient at risk for falls? (OERDFALLS):				

Name: Aaliyah [REDACTED]

MRN: 1116206
Account#: K20034006872

Print Time: 8/29/2017 06:16:19

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Physician Documentation Con't.

MODE OF TRANSPORTATION : (OERDTRANS): Stretcher				
O2: (OEADO2): No				
Priority RAD: Stat				
REASON FOR EXAM: (OERDEXAM): Breathing Difficulty				
Order	Status	Time	By	For
Blood Culture, Bacteria x1	Ordered	08/28/17 01:35	hk1	ep
	In Process Unspecified	08/28/17 01:44	Dispatcher MedHost	
Notes:	Order Method: Verbal - Read back			
	Sign off: Brandhurst, Roy, MD 08/28/17 01:39			
Ordering Location: ERSPC100.1				
Priority LAB: Stat				
Quantity 1: 1				
COLLECTED BY NURSE? (Y/N) (OELBCBN): No				
Source (OEMICbid): Venipuncture				
Order	Status	Time	By	For
Magnesium Sulfate 850 mg IVPB once; over 20 minutes	Ordered	08/28/17 01:39	rb	rb
	Administered	08/28/17 02:07	hk1	
Notes:	Order Method: Electronic			
08/28/17 02:07 Administered: Magnesium Sulfate 850 mg IVPB in right antecubital over 33 mins				hk1
Order	Status	Time	By	For
Albuterol 5 mg Inhalation Continuous	Ordered	08/28/17 01:43	jm15	rb
	Administered	08/28/17 01:47	jm15	
Notes:	Order Method: Verbal - Read back			
	Sign off: Brandhurst, Roy, MD 08/28/17 01:56			
08/28/17 01:47 Administered: Albuterol 5 mg Inhalation				jm15
Order	Status	Time	By	For
Vital Signs	Ordered	08/28/17 02:43	rb	rb
	Completed	08/28/17 02:49	Helen Kirkikis	
Notes:	Order Method: Electronic			

Order Signatures:

Paul, Edward, MD	MD ep	Kirkikis, Helen, RN	RN hk1
Brandhurst, Roy, MD	MD rb	Morrow, Jennifer, RN	RN jm15

Disposition:

03:04 Electronically signed by: R. Brandhurst M.D. I personally performed the services described in this documentation as scribed in my presence and it is both accurate and complete. Disposition. rb

Disposition:

08/28/17 03:07 Hospitalization ordered by Tran, Sharon for Inpatient Admission. Preliminary diagnosis is Mild persistent asthma with status asthmaticus.

Name: Aaliyah [REDACTED]

MRN: 1116206
Account#: K20034006872

Print Time: 8/29/2017 06:16:19

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Physician Documentation Con't.

- Bed requested for Specific Bed.
- Status is Inpatient Admission.
- Condition is Fair.
- Problem is an acute exacerbation.
- Symptoms have improved.

hk1

Critical Care Time Excluding Procedures:

03:04 Critical care time: Consultation: 5 minutes, Family Intervention: 10 minutes, Patient Care: 25 minutes, Documentation: 10 minutes. Total time: 50 minutes

rb

Signatures:

Dispatcher MedHost

EDMS

Brandhurst, Roy, MD

MD rb

Morrow, Jennifer, RN

RN jm15

Kemp, Christine, ED Tech

ED
Tech ck3

Kirkikis, Helen, RN

RN hk1

Name: Aaliyah [REDACTED]

Print Time: 8/29/2017 06:16:19

MRN: 1116206
Account#: K20034006872
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Generated from 08/28/2017 00:00 to 09/01/2017 23:59

Pt Name: [REDACTED] L
Pt ID: 0101757329
DOB: 10/01/2013
Adm DTime: 08/28/2017
Dsch DTime: 08/30/2017
Entity: Willis-Knighton South
Dx:

MRN: 1116206
Acct No: K20034006872
Age/Sex: 3Y/F
Attn Dr: Tran, Sharon MD

Order #: 2765650 Soarian Order #: 2289259
Order Type/Sub Type: Medication/IV/Injectable
Order As Written: SODIUM CHLORIDE 0.9% (50 ML bag) MAGNESIUM SULFATE 50% 850 MG = 1.7 ML Intravenous @155mL/Hour Over 0.33H for 1 Bags

Order History

Order Source:
Ordered By: Roy Estel Brandhurst, MD
Entered By: SRX on 8/28/2017 1:56:00AM

Validated by SRX on 08/28/2017 01:56

Validated by Meghan A Wallace, RN on 08/28/2017 04:40

Discontinue by HSF_JS on 08/30/2017 23:06

Electronically Signed By:

Electronically Signed by:
BRANDHURST, ROY ESTEL M.D.
on 13-Sep-2017 19:20:55 -0500

Order #: 2765004
Order Type/Sub Type: Admit/Discharge/Transfer/Admit
Order As Written: Patient status: Inpatient

Order History

Order Source: CPOE Order
Ordered By: Roy Estel Brandhurst, MD
Entered By: Roy Estel Brandhurst, MD on 8/28/2017 3:22:00AM

Order Entered by Roy Estel Brandhurst, MD on 08/28/2017 03:22

Active by Meghan A Wallace, RN on 08/28/2017 04:40

Discontinue by HSF_JS on 08/30/2017 23:02

Reason for Revision: Visit is closed for the patient

Electronically Signed By: Roy Estel Brandhurst, MD on 8/28/2017 3:22:00AM

Order #: 2765026
Order Type/Sub Type: Admit/Discharge/Transfer/Admit
Order As Written: Attending physician Sharon Nhu Tran, MD Complete care turned over to listed Attending. Please contact listed Attending for any changes in patient status or questions related to admission orders and patient care.

Order History

Order Source: CPOE Order
Ordered By: Roy Estel Brandhurst, MD
Entered By: Roy Estel Brandhurst, MD on 8/28/2017 3:22:00AM

Order Entered by Roy Estel Brandhurst, MD on 08/28/2017 03:22

Active by Meghan A Wallace, RN on 08/28/2017 04:40

Discontinue by HSF_JS on 08/30/2017 23:02

Reason for Revision: Visit is closed for the patient

Electronically Signed By: Roy Estel Brandhurst, MD on 8/28/2017 3:22:00AM

Pt. Name: [REDACTED] L

Entity: Willis-Knighton South

Adm Date: 08/28/2017

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MRN: 1116206

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Orders Report

ORE 0149 DSCH.rpt version v1.00

Generated By: Workflow

Generated On: 31-Aug-17 15:54

Report Content Represents Data Available for the specified Visit as of the Generated On Date/Time

Generated from 08/28/2017 00:00 to 09/01/2017 23:59

Pt Name:	██████████ L	MRN:	1116206
Pt ID:	0101757329	Acct No:	K20034006872
DOB:	10/01/2013	Age/Sex:	3Y/F
Adm DTime:	08/28/2017	Attn Dr:	Tran, Sharon MD
Dsch DTime:	08/30/2017		
Entity:	Willis-Knighton South		
Dx:			

Order #: 2765027
Order Type/Sub Type: Admit/Discharge/Transfer/Level of Care
Order As Written: Level of care Medical Surgical Unit

Order History

Order Source: CPOE Order
Ordered By: Roy Estel Brandhurst, MD
Entered By: Roy Estel Brandhurst, MD on 8/28/2017 3:22:00AM
Order Entered by Roy Estel Brandhurst, MD on 08/28/2017 03:22
Active by Meghan A Wallace, RN on 08/28/2017 04:40
Discontinue by HSF_JS on 08/30/2017 23:02
Reason for Revision: Visit is closed for the patient
Electronically Signed By: Roy Estel Brandhurst, MD on 8/28/2017 3:22:00AM

Order #: 2765031
Order Type/Sub Type: Dietary/Oral
Order As Written: Diet: Regular

Order History

Order Source: CPOE Order
Ordered By: Roy Estel Brandhurst, MD
Entered By: Roy Estel Brandhurst, MD on 8/28/2017 3:22:00AM
Order Entered by Roy Estel Brandhurst, MD on 08/28/2017 03:22
Active by Meghan A Wallace, RN on 08/28/2017 04:40
Discontinue by HSF_JS on 08/30/2017 23:02
Reason for Revision: Visit is closed for the patient
Electronically Signed By: Roy Estel Brandhurst, MD on 8/28/2017 3:22:00AM

Order #: 2765005
Order Type/Sub Type: General/Clinical Factors
Order As Written: Diagnosis: status asthmaticus, hypoxemia

Order History

Order Source: CPOE Order
Ordered By: Roy Estel Brandhurst, MD
Entered By: Roy Estel Brandhurst, MD on 8/28/2017 3:22:00AM
Order Entered by Roy Estel Brandhurst, MD on 08/28/2017 03:22
Active by Meghan A Wallace, RN on 08/28/2017 04:40
Discontinue by HSF_JS on 08/30/2017 23:02
Reason for Revision: Visit is closed for the patient
Electronically Signed By: Roy Estel Brandhurst, MD on 8/28/2017 3:22:00AM

Pt. Name: ██████████ L

MRN: 1116206

Orders Report

Entity: Willis-Knighton South

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Adm Date: 08/28/2017

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Generated from 08/28/2017 00:00 to 09/01/2017 23:59

Pt Name: [REDACTED] L
Pt ID: 0101757329
DOB: 10/01/2013
Adm DTime: 08/28/2017
Dsch DTime: 08/30/2017
Entity: Willis-Knighton South
Dx:

MRN: 1116206
Acct No: K20034006872
Age/Sex: 3Y/F
Attn Dr: Tran, Sharon MD

Order #: 2765001 Soarian Order #: 2308809
Order Type/Sub Type: Medication/IV/
Order As Written: KCL 20 MEQ/D5W-0.45% NS 1000ML (1000 ML bag) Intravenous @55mL/Hour Over 18.25H for 3 Days

Order History

Order Source: CPOE Order
Ordered By: Roy Estel Brandhurst, MD
Entered By: Roy Estel Brandhurst, MD on 8/28/2017 3:22:00AM
Order Entered by Roy Estel Brandhurst, MD on 8/28/2017 03:22
Validated by SRX on 08/28/2017 03:25
In progress by Meghan A Wallace, RN on 08/28/2017 04:40
Discontinue by SRX on 08/28/2017 14:39
Discontinue by Sharon Nhu Tran, MD on 08/28/2017 14:39
Discontinue by Catrina J Lewis, RN on 08/28/2017 15:03
Electronically Signed By: Roy Estel Brandhurst, MD on 8/28/2017 3:22:00AM

Order #: 2765002 Soarian Order #: 2308810
Order Type/Sub Type: Medication/IV/
Order As Written: METHYLPREDNISOLONE (SOLU-MEDROL) 15 MG = 0.375 ML Intravenous VIAL Q12H for 31 Days

Order History

Order Source: CPOE Order
Ordered By: Roy Estel Brandhurst, MD
Entered By: Roy Estel Brandhurst, MD on 8/28/2017 3:22:00AM
Order Entered by Roy Estel Brandhurst, MD on 08/28/2017 03:22
Validated by SRX on 08/28/2017 03:26
Validated by Meghan A Wallace, RN on 08/28/2017 04:40
Discontinue by SRX on 08/29/2017 13:46
Discontinue by Sharon Nhu Tran, MD on 08/29/2017 13:46
Discontinue by Catrina J Lewis, RN on 08/29/2017 13:48
Electronically Signed By: Roy Estel Brandhurst, MD on 8/28/2017 3:22:00AM

Pt. Name [REDACTED] L
Entity: Willis-Knighton South
Adm Date: 08/28/2017

MRN: 1116206
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Generated from 08/28/2017 00:00 to 09/01/2017 23:59

Pt Name: [REDACTED] L
Pt ID: 0101757329
DOB: 10/01/2013
Adm DTime: 08/28/2017
Dsch DTime: 08/30/2017
Entity: Willis-Knighton South
Dx:

MRN: 1116206
Acct No: K20034006872
Age/Sex: 3Y/F
Attn Dr: Tran, Sharon MD

Order #: 2765003 Soarian Order #: 2308811
Order Type/Sub Type: Medication/IV/
Order As Written: IBUPROFEN (PEDIA-PROFEN) 160 MG = 8 ML Oral SUSP Q6H for 31 Days, PRN TEMP GREATER THAN 100.4
Order History
Order Source: CPOE Order
Ordered By: Roy Estel Brandhurst, MD
Entered By: Roy Estel Brandhurst, MD on 8/28/2017 3:22:00AM
Order Entered by Roy Estel Brandhurst, MD on 08/28/2017 03:22
Validated by SRX on 08/28/2017 03:26
Discontinue by SRX on 08/28/2017 04:39
Discontinue by Meghan A Wallace, RN on 08/28/2017 04:40
Electronically Signed By: Roy Estel Brandhurst, MD on 8/28/2017 3:22:00AM

Order #: 2765032 Soarian Order #: 2308820
Order Type/Sub Type: Medication/IV/Nebulized
Order As Written: IPRATROPIUM 0.02% (ATROVENT 0.02%) 0.5 MG = 2.5 ML Nebulization SOLN Q6H RT for 31 Days
Order History
Order Source: CPOE Order
Ordered By: Roy Estel Brandhurst, MD
Entered By: Roy Estel Brandhurst, MD on 8/28/2017 3:22:00AM
Order Entered by Roy Estel Brandhurst, MD on 08/28/2017 03:22
Validated by SRX on 08/28/2017 03:26
Validated by Meghan A Wallace, RN on 08/28/2017 04:40
Validated by Chad A Earley, RT on 08/28/2017 04:53
In-progress by Gentry N Grisham, RT on 08/29/2017 10:32
Discontinue by SRX on 08/29/2017 13:46
Discontinue by Sharon Nhu Tran, MD on 08/29/2017 13:46
Discontinue by Catrina J Lewis, RN on 08/29/2017 13:48
Electronically Signed By: Roy Estel Brandhurst, MD on 8/28/2017 3:22:00AM

Pt. Name: [REDACTED] L
Entity: Willis-Knighton South
Adm Date: 08/28/2017

MRN: 1116206
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Pt Name: [REDACTED] L
Pt ID: 0101757329
DOB: 10/01/2013
Adm DTime: 08/28/2017
Dsch DTime: 08/30/2017
Entity: Willis-Knighton South
Dx:

MRN: 1116206
Acct No: K20034006872
Age/Sex: 3Y/F
Attn Dr: Tran, Sharon MD

Order #: 2765033 Soarian Order #: 2308821
Order Type/Sub Type: Medication/IV/Nebulized
Order As Written: ALBUTEROL 0.083% (PROVENTIL 0.083%) 2.5 MG = 3 ML Nebulization SOLN Q2H RT for 31 Days

Order History

Order Source: CPOE Order
Ordered By: Roy Estel Brandhurst, MD
Entered By: Roy Estel Brandhurst, MD on 8/28/2017 3:22:00AM
Order Entered by Roy Estel Brandhurst, MD on 08/28/2017 03:22
Validated by SRX on 08/28/2017 03:26
Validated by Meghan A Wallace, RN on 08/28/2017 04:40
Validated by Chad A Earley, RT on 08/28/2017 04:53
In progress by Gentry N Grisham, RT on 08/28/2017 07:34
In progress by Gentry N Grisham, RT on 08/28/2017 15:40
In progress by Gentry N Grisham, RT on 08/29/2017 10:32
Discontinue by SRX on 08/29/2017 13:46
Discontinue by Sharon Nhu Tran, MD on 08/29/2017 13:46
Discontinue by Catrina J Lewis, RN on 08/29/2017 13:48
Electronically Signed By: Roy Estel Brandhurst, MD on 8/28/2017 3:22:00AM

Order #: 2765029
Order Type/Sub Type: Nursing/Activity
Order As Written: Bedrest with bathroom privileges

Order History

Order Source: CPOE Order
Ordered By: Roy Estel Brandhurst, MD
Entered By: Roy Estel Brandhurst, MD on 8/28/2017 3:22:00AM
Order Entered by Roy Estel Brandhurst, MD on 08/28/2017 03:22
Active by Meghan A Wallace, RN on 08/28/2017 04:40
Complete by Meghan A Wallace, RN on 08/28/2017 04:41
Electronically Signed By: Roy Estel Brandhurst, MD on 8/28/2017 3:22:00AM

Pt. Name: [REDACTED] L
Entity: Willis-Knighton South
Adm Date: 08/28/2017

MRN: 1116206
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Pt Name: [REDACTED] L
Pt ID: 0101757329
DOB: 10/01/2013
Adm DTime: 08/28/2017
Dsch DTime: 08/30/2017
Entity: Willis-Knighton South
Dx:

MRN: 1116206
Acct No: K20034006872
Age/Sex: 3Y/F
Attn Dr: Tran, Sharon MD

Order #: 2765030
Order Type/Sub Type: Respiratory/Respiratory General
Order As Written: Oxygen Protocol

Order History

Order Source: CPOE Order
Ordered By: Roy Estel Brandhurst, MD
Entered By: Roy Estel Brandhurst, MD on 8/28/2017 3:22:00AM
Order Entered by Roy Estel Brandhurst, MD on 08/28/2017 03:22
Active by Meghan A Wallace, RN on 08/28/2017 04:40
Active by Chad A Earley, RT on 08/28/2017 04:53
Active by Gentry N Grisham, RT on 08/28/2017 07:34
Discontinue by Sharon Nhu Tran, MD on 08/28/2017 14:39
Discontinue by Catrina J Lewis, RN on 08/28/2017 15:03
Electronically Signed By: Roy Estel Brandhurst, MD on 8/28/2017 3:22:00AM

Order #: 2765028
Order Type/Sub Type: Vital Signs/
Order As Written: Vital signs per Vital Signs policy

Order History

Order Source: CPOE Order
Ordered By: Roy Estel Brandhurst, MD
Entered By: Roy Estel Brandhurst, MD on 8/28/2017 3:22:00AM
Order Entered by Roy Estel Brandhurst, MD on 08/28/2017 03:22
Active by Meghan A Wallace, RN on 08/28/2017 04:40
Discontinue by HSF_JS on 08/30/2017 23:02
Reason for Revision: Visit is closed for the patient
Electronically Signed By: Roy Estel Brandhurst, MD on 8/28/2017 3:22:00AM

Pt. Name: [REDACTED] L
Entity: Willis-Knighton South
Adm Date: 08/28/2017

MRN: 1116206
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Pt Name: [REDACTED] L
Pt ID: 0101757329
DOB: 10/01/2013
Adm DTime: 08/28/2017
Dsch DTime: 08/30/2017
Entity: Willis-Knighton South
Dx:

MRN: 1116206
Acct No: K20034006872
Age/Sex: 3Y/F
Attn Dr: Tran, Sharon MD

Order #: 2766151 Soarian Order #: 2311359
Order Type/Sub Type: Medication/IV/
Order As Written: IBUPROFEN (PEDIA-PROFEN) 160 MG = 8 ML Oral SUSP Q6H PRN TEMP > 100.4 DEGREES F. for 31 Days, PRN TEMP GREATER THAN 100.4

Order History

Order Source:

Ordered By: Roy Estel Brandhurst, MD
Entered By: SRX on 8/28/2017 4:39:00AM

Validated by SRX on 08/28/2017 04:39

Validated by Meghan A Wallace, RN on 08/28/2017 04:40

Suspend by MedSys on 08/30/2017 15:54

Discontinue by HSF_JS on 08/30/2017 23:06

Electronically Signed By:

Electronically Signed by:
BRANDHURST, ROY ESTEL M.D.
on 13-Sep-2017 19:20:55 -0500

Order #: 2779931 Soarian Order #: 2318189
Order Type/Sub Type: Medication/IV/
Order As Written: KCL 20 MEQ/D5W-0.45%NS 1000ML (1000 ML bag) Intravenous @35mL/Hour Over 28.58H for 3 Days

Order History

Order Source:

CPOE Order
Ordered By: Sharon Nhu Tran, MD
Entered By: Sharon Nhu Tran, MD on 8/28/2017 2:39:00PM

Active by Sharon Nhu Tran, MD on 08/28/2017 14:39

Validated by SRX on 08/28/2017 14:42

Validated by Catrina J Lewis, RN on 08/28/2017 15:03

Discontinue by SRX on 08/29/2017 13:46

Discontinue by Sharon Nhu Tran, MD on 08/29/2017 13:46

Discontinue by Catrina J Lewis, RN on 08/29/2017 13:48

Electronically Signed By: Sharon Nhu Tran, MD on 8/28/2017 2:39:00PM

Pt. Name [REDACTED] L

Entity: Willis-Knighton South

Adm Date: 08/28/2017

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MRN: 1116206

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Generated from 08/28/2017 00:00 to 09/01/2017 23:59

Pt Name: [REDACTED] L
Pt ID: 0101757329
DOB: 10/01/2013
Adm DTime: 08/28/2017
Dschr DTime: 08/30/2017
Entity: Willis-Knighton South
Dx:

MRN: 1116206
Acct No: K20034006872
Age/Sex: 3Y/F
Attn Dr: Tran, Sharon MD

Order #: 2779917
Order Type/Sub Type: Respiratory/Oxygen
Order As Written: Oxygen administration Maintain O2 sats = or >92%, wean to RA as tolerated, 0. L/Min, Nasal cannula

Order History

Order Source: CPOE Order
Ordered By: Sharon Nhu Tran, MD
Entered By: Sharon Nhu Tran, MD on 8/28/2017 2:39:00PM
Order Entered by Sharon Nhu Tran, MD on 08/28/2017 14:39
Active by Catrina J Lewis, RN on 08/28/2017 15:03
Active by Gentry N Grisham, RT on 08/28/2017 15:40
Active by Fredda M Huckabee, RT on 08/29/2017 19:47
Active by Shannon L Thames, RT on 08/30/2017 12:17
Discontinue by HSF_JS on 08/30/2017 23:02
Reason for Revision: Visit is closed for the patient
Electronically Signed By: Sharon Nhu Tran, MD on 8/28/2017 2:39:00PM

Order #: 2779918 Soarian Order #: 2311779
Order Type/Sub Type: Medication/IV/
Order As Written: ACETAMINOPHEN (TYLENOL) 240 MG = 7.495 ML Oral SOLN Q4H PRN TEMP > 100.4F/PAIN for 31 Days

Order History

Order Source: CPOE Order
Ordered By: Sharon Nhu Tran, MD
Entered By: Sharon Nhu Tran, MD on 8/28/2017 2:41:00PM
Order Entered by Sharon Nhu Tran, MD on 08/28/2017 14:41
Validated by SRX on 08/28/2017 14:42
Validated by Catrina J Lewis, RN on 08/28/2017 15:03
Suspend by MedSys on 08/30/2017 15:54
Discontinue by HSF_JS on 08/30/2017 23:06
Electronically Signed By: Sharon Nhu Tran, MD on 8/28/2017 2:41:00PM

Pt. Name: [REDACTED] L
Entity: Willis-Knighton South
Adm Date: 08/28/2017

MRN: 1116206
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Orders Report
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Generated from 08/28/2017 00:00 to 09/01/2017 23:59

Pt Name: [REDACTED] L
Pt ID: 0101757329
DOB: 10/01/2013
Adm DTime: 08/28/2017
Dsch DTime: 08/30/2017
Entity: Willis-Knighton South
Dx:

MRN: 1116206
Acct No: K20034006872
Age/Sex: 3Y/F
Attn Dr: Tran, Sharon MD

Order #: 2803592 Soarian Order #: 2338660
Order Type/Sub Type: Medication/IV/
Order As Written: PREDNISOLONE (PRELONE *BKC*) 15 MG = 5 ML Oral SOLN 2XDAY First Dose Now for 31 Days

Order History

Order Source: CPOE Order
Ordered By: Sharon Nhu Tran, MD
Entered By: Sharon Nhu Tran, MD on 8/29/2017 1:46:00PM
Order Entered by Sharon Nhu Tran, MD on 08/29/2017 13:46
Active by Catrina J. Lewis, RN on 08/29/2017 13:48
Validated by SRX on 08/29/2017 13:54
Suspend by MedSys on 08/30/2017 15:54
Discontinue by HSF_JS on 08/30/2017 23:06
Electronically Signed By: Sharon Nhu Tran, MD on 8/29/2017 1:46:00PM

Order #: 2803576 Soarian Order #: 2356557
Order Type/Sub Type: Medication/IV/Nebulized
Order As Written: ALBUTEROL 0.083% (PROVENTIL 0.083%) 2.5 MG = 3 ML Nebulization SOLN Q3H RT for 30 Days

Order History

Order Source: CPOE Order
Ordered By: Sharon Nhu Tran, MD
Entered By: Sharon Nhu Tran, MD on 8/29/2017 1:46:00PM
Active by Sharon Nhu Tran, MD on 08/29/2017 13:46
Active by Catrina J. Lewis, RN on 08/29/2017 13:48
Validated by SRX on 08/29/2017 13:54
In progress by Fredda M. Huckabee, RT on 08/29/2017 19:47
Discontinue by SRX on 08/30/2017 11:50
Discontinue by Sharon Nhu Tran, MD on 08/30/2017 11:50
Discontinue by Amanda G. Fortiz, RN on 08/30/2017 12:00
Electronically Signed By: Sharon Nhu Tran, MD on 8/29/2017 1:46:00PM

Pt. Name [REDACTED] L
Entity: Willis-Knighton South
Adm Date: 08/28/2017

MRN: 1116206
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Orders Report
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Generated from 08/28/2017 00:00 to 09/01/2017 23:59

Pt Name: [REDACTED] L
Pt ID: 0101757329
DOB: 10/01/2013
Adm DTime: 08/28/2017
Dschr DTime: 08/30/2017
Entity: Willis-Knighton South
Dx:

MRN: 1116206
Acct No: K20034006872
Age/Sex: 3Y/F
Attn Dr: Tran, Sharon MD

Order #: 2823417 Soarian Order #: 2362872
Order Type/Sub Type: Medication/IV/Nebulized
Order As Written: ALBUTEROL 0.083% (PROVENTIL 0.083%) 2.5 MG = 3 ML Nebulization SOLN Q4H RT for 29 Days

Order History

Order Source: CPOE Order
Ordered By: Sharon Nhu Tran, MD
Entered By: Sharon Nhu Tran, MD on 8/30/2017 11:50:00AM
Active by Sharon Nhu Tran, MD on 08/30/2017 11:50
Validated by SRX on 08/30/2017 11:51
Validated by Amanda G Fortiz, RN on 08/30/2017 12:00
Validated by Shannon L Thames, RT on 08/30/2017 12:17
Suspend by MedSys on 08/30/2017 15:54
Discontinue by HSF_JS on 08/30/2017 23:06
Electronically Signed By: Sharon Nhu Tran, MD on 8/30/2017 11:50:00AM

Order #: 2826971
Order Type/Sub Type: Admit/Discharge/Transfer/Discharge
Order As Written: Discharge to: (specify) Home

Order History

Order Source: CPOE Order
Ordered By: Sharon Nhu Tran, MD
Entered By: Sharon Nhu Tran, MD on 8/30/2017 2:04:00PM
Order Entered by Sharon Nhu Tran, MD on 08/30/2017 14:04
Active by Amanda G Fortiz, RN on 08/30/2017 14:12
Complete by Amanda G Fortiz, RN on 08/30/2017 14:18
Electronically Signed By: Sharon Nhu Tran, MD on 8/30/2017 2:04:00PM

Pt. Name: [REDACTED] L

Entity: Willis-Knighton South

Adm Date: 08/28/2017

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MRN: 1116206

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WILLIS-TOWNSEND HEALTH SYSTEM

Pediatric Hospitalist Progress Note

Date: 8/30/17 Time: _____ Name: _____

Interval History: Resting in ☐ bed ☒ chair ☐ crib ☒ No new problems/complaints

☐ Other Abt. on RA. Toluene kg. Dist
Day after

Meds: ☒ Reviewed Remarks _____

☒ Discussed Assessment/Plan with ☐ patient ☒ family at ☒ bedside ☐ per phone

ROS: ☒ 10 systems reviewed otherwise Negative

Positive: _____

Interval Physical Exam:

Vitals: temp 98.5 HR 71 RR 24 O2 sat 100 RA

General: ☒ Well-hydrated ☒ WN ☒ NAD ☒ Nontoxic ☐ Remarks _____

HEENT: ☒ Normocephalic atraumatic ☐ Anterior fontanelle open & flat ☒ PERRL ☒ Conjunctiva clear

☒ No rhinorrhea/congestion ☐ Nasal flaring ☒ Tympanic membranes normal bil ☒ Oral mucosa moist ☒ Pharynx normal

☐ Remarks _____

Neck: ☐ Normal ☒ Supple ☐ No rigidity ☐ Adenopathy ☐ Masses ☐ Jugular vein distention ☐ Remarks _____

Heart: ☐ Normal ☒ S1S2 normal ☐ RRR ☐ Murmur ☐ Remarks _____

Lungs: ☒ Normal ☒ CTA bil ☒ Unlabored Air movement: ☒ Good ☐ Fair ☐ Poor ☐ Rales ☐ Rhonchi

☐ Wheeze (end expiratory/inspiratory) ☐ Crackles ☐ Retractions ☐ Stridor ☐ Remarks _____

Abdomen: ☒ Normal ☒ Soft ☒ Non-tender ☒ Non-distended ☒ Normal active bowel sounds ☐ Hepatosplenomegaly

☐ Masses ☐ Remarks _____

Extremities: ☐ Normal ☐ Cyanosis ☒ Capillary refill less than 2 seconds ☐ Edema ☐ _____ Pulses

☐ Remarks _____

Musculoskeletal: ☒ Normal ☐ Joints full ROM ☐ Pain ☐ Contractures ☐ Weakness ☐ Remarks _____

Skin: ☒ Normal ☒ Warm/dry ☐ Rash ☐ Remarks _____

Neuro: ☒ Normal/nonfocal ☒ Awake ☒ Alert ☐ Oriented ☐ Times 3 ☐ Irritable ☐ Sedated ☐ CN 2-12 intact

☐ Remarks _____

Lab: ☐ Reviewed ☐ Abnormals

Ca _____

Segs _____

Alb _____ Ast/Alt _____

Bands _____

Aik/Phos _____

Lymphs _____

T/Dbili _____

Other: _____

Impression: 3 y/o c status
asthma, URI, autism.

clinically improved. Distress &
hypoxia resolved

Physician Signature _____ Date/Time 8/30/17 2pm

☒ Sharon Tran, M.D. (2944)

☐ Greg Oji, M.D. (2977)

☐ Craig Chu, MD (3101)

☐ Anna Craig, MD (3110)

#2346592

Plan: ☒ See orders ☒ Continue medical management
☐ Recommendations per consultant/s: _____

☒ Follow labs ☒ O2, Respiratory Therapy

☐ Continue antibiotics, Day # _____

☐ Continue therapy/Rehab ☐ Nutrition support

DK home day on PO steroids, Alb today
Phenol. Discharge Asthma & DIC plus E
Hum & Am at home. Plan to Discharge
Also Alim. appt scheduled. Plan to Dis

☒ Spent greater than 30 minutes on discharge

☒ Spent extended time counseling patient and family

☒ Total time spent 60 minutes.

☒ Face to face 50 minutes.

PN650

Revised 10/04/2016

Committee Approved 10/17/2016

Page: 1 of 1



PN0005



HENDERSON, AALIYAH L

10/01/13 3Y 10M

Tran, Sharon N M.D. S5517

K20034006872

08/28/17



WILLIS-TOWNSEND HEALTH SYSTEM

Pediatric Hospitalist Progress Note

Date: 8/29/17 Time: _____ Name: _____

Interval History: Resting in ☒ bed ☐ chair ☐ crib ☒ No new problems/complaints

☐ Other Advance. on RA.

Doing much better today

Meds: ☒ Reviewed Remarks _____

☒ Discussed Assessment/Plan with ☐ patient ☒ family at ☒ bedside ☐ per phone

ROS: ☒ 10 systems reviewed otherwise Negative Positive: _____

Interval Physical Exam:

Vitals: temp 98.1 HR 130 RR 32 O2 sat 99 RA

General: ☒ Well-hydrated ☒ WN ☐ NAD ☒ Nontoxic ☐ Remarks _____

HEENT: ☒ Normocephalic atraumatic ☐ Anterior fontanelle open & flat ☒ PERRL ☒ Conjunctiva clear

☒ No rhinorrhea/congestion ☐ Nasal flaring ☒ Tympanic membranes normal bil ☒ Oral mucosa moist ☒ Pharynx normal

☐ Remarks _____

Neck: ☒ Normal ☒ Supple ☐ No rigidity ☐ Adenopathy ☐ Masses ☐ Jugular vein distention ☐ Remarks _____

Heart: ☒ Normal ☒ S1S2 normal ☐ RRR ☐ Murmur ☐ Remarks _____

Lungs: ☒ Normal ☒ CTA bil ☒ Unlabored Air movement: ☒ Good ☐ Fair ☐ Poor ☐ Rales ☐ Rhonchi

☐ Wheeze (end expiratory/inspiratory) ☐ Crackles ☐ Retractions ☐ Stridor ☐ Remarks _____

Abdomen: ☒ Normal ☒ Soft ☒ Non-tender ☒ Non-distended ☒ Normal active bowel sounds ☐ Hepatosplenomegaly

☐ Masses ☐ Remarks _____

Extremities: ☒ Normal ☐ Cyanosis ☒ Capillary refill less than 2 seconds ☐ Edema ☐ _____ Pulses

☐ Remarks _____

Musculoskeletal: ☒ Normal ☐ Joints full ROM ☐ Pain ☐ Contractures ☐ Weakness ☐ Remarks _____

Skin: ☒ Normal ☐ Warm/dry ☐ Rash ☐ Remarks _____

Neuro: ☒ Normal/nonfocal ☒ Awake ☒ Alert ☐ Oriented ☐ Times 3 ☐ Irritable ☐ Sedated ☐ CN 2-12 intact

☐ Remarks _____

Lab: ☐ Reviewed ☐ Abnormals

Ca _____ Segs _____

Alb _____ Ast/Alt _____ Bands _____

Alk/Phos _____ Lymphs _____

T/Dbili _____

Other: _____

Impression: 3y/o c Asthma admission
acute resp distress - resolved, UEL.

Plan: ☒ See orders ☒ Continue medical management

☐ Recommendations per consultant/s: _____

Clinically improving

Asthma Education provided today by

Asthma Educator. Will follow up with Asthma

Physician Signature _____ Date/Time 8/29/17 130pm

☒ Sharon Tran, M.D. (2944) ☐ Greg Oji, M.D.(2977)

☐ Craig Chu, MD (3101) ☐ Anna Craig, MD (3110)

☐ Follow labs ☒ O2, Respiratory Therapy

☐ Continue antibiotics, Day # _____

☐ Continue therapy/Rehab ☐ Nutrition support

Advance Alb to 0.3 before discharge

D/C Asthma

A to PO. Berods

Wash 1x

☐ Spent greater than 30 minutes on discharge

☐ Spent extended time counseling patient and family

☐ Total time spent _____ minutes.

☐ Face to face _____ minutes.



PN0005



HENDERSON, AALIYAH L
10/01/13 3Y 10M
Tran, Sharon N M.D. S5517
K20034006872 08/28/17

RUN DATE: 09/03/17

WILLIS-KNIGHTON HEALTH SYSTEM LABORATORIES

PAGE 1

RUN TIME: 0206

WKHS Summary Discharge Report

WK=2600 Greenwood Rd Shreveport, LA 71103 WKS=2510 BertKounsIndLoop Shreveport, LA 71118 WKB=2400 Hospital Dr Bossier City, LA 71112 WKP=8001 Youree Dr Shreveport, LA 71115

PATIENT: [REDACTED] L ACCT #: K20034006872 LOC: S5E1 U #: K000629604
 DOB: 10/01/13 AGE/SX: 3Y 10M/F ROOM: S5517 REG: 08/28/17
 ATT DR: Tran, Sharon N M.D. STATUS: DIS IN BED: A DIS: 08/30/17

CHEMISTRY
 GENERAL CHEMISTRY

Date	AUG 28		
Time	0137	Reference	Units
Glucose	125 (A) H	(70-109)	mg/dL
(A) Glucose Reference Ranges:			
Fasting Glucose Level: 70-109 mg/dL			
Impaired Fasting Glucose: 110-125 mg/dL			
Defined by the ADA as a category at risk for future diabetes and cardiovascular disease.			
The American Diabetes Association (ADA) recommends the following criteria for the diagnosis of diabetes:			
Abnormal Fasting Glucose: ≥ 126 mg/dL			
Symptoms of diabetes and a random glucose: ≥ 200 mg/dL			
Potassium	4.5	(3.5-5.1)	mmol/L
Sodium	144	(137-145)	mmol/L
Chloride	106	(98-107)	mmol/L
CO2	23	(21-32)	mmol/L
BUN	9	(7-20)	mg/dL
Creatinine	0.45		mg/dL
Calcium	9.5	(8.4-10.2)	mg/dL
Anion Gap	15.0	(5.0-15.0)	mmol/L
eGFR	(B)	(>60)	See Below

(B) Test not performed

eGFR *non- [REDACTED] (C) (>60) see below

(C) Test not performed

RUN DATE: 09/03/17 WILLIS-KNIGHTON HEALTH SYSTEM LABORATORIES PAGE 2
 RUN TIME: 0206 WKHS Summary Discharge Report
 WK=2600 Greenwood Rd WKS=2510 BertKounsIndLoop WKB=2400 Hospital Dr WKP=8001 Youree Dr
 Shreveport, LA 71103 Shreveport, LA 71118 Bossier City, LA 71112 Shreveport, LA 71115

PATIENT: [REDACTED] L ACCT #: K20034006872 LOC: S5E1 U #: K000629604
 DOB: 10/01/13 AGE/SX: 3Y 10M/F ROOM: S5517 REG: 08/28/17
 ATT DR: Tran, Sharon N M.D. STATUS: DIS IN BED: A DIS: 08/30/17

HEMATOLOGY

Date Time	AUG 28 0137	Reference	Units
White Blood Cel	15.1 H	(4.0-12.0)	10E3/uL
Red Blood Cell	4.41	(4.1-5.2)	10E6/uL
Hemoglobin	11.0 L	(11.8-14.7)	g/dL
Hematocrit	34.1 L	(35.0-44.0)	%
MCV	77.2	(74.0-89.0)	fL
MCH	24.9 L	(27.1-34.2)	pg
MCHC	32.2 L	(33.0-35.6)	g/dL
RDW	13.5	(12.0-14.0)	%
Platelet Count	266	(130-351)	10E3/uL
Neutrophils	80.2	(Not Estab.)	%
Lymphocytes	11.7	(Not Estab.)	%
Monocytes	5.9	(3-10)	%
Eosinophils	1.9	(0.0-8.0)	%
Basophils	0.3	(0.0-3.0)	%
Neutrophils-ABS	12.1	(Not Estab.)	10E3/uL
Lymphocytes-ABS	1.8	(Not Estab.)	10E3/uL
Monocytes-ABS	0.9	(Not Estab.)	10E3/uL
Eosinophils-ABS	0.3	(Not Estab.)	10E3/uL
Basophils-ABS	0.0	(Not Estab.)	10E3/uL

** CONTINUED ON NEXT PAGE **

RUN DATE: 09/03/17

WILLIS-KNIGHTON HEALTH SYSTEM LABORATORIES

PAGE 3

RUN TIME: 0206

WKHS Summary Discharge Report

WK=2600 Greenwood Rd
Shreveport, LA 71103

WKS=2510 BertKounsIndLoop
Shreveport, LA 71118

WKB=2400 Hospital Dr
Bossier City, LA 71112

WKP=8001 Youree Dr
Shreveport, LA 71115

PATIENT: [REDACTED] L
DOB: 10/01/13
ATT DR: Tran, Sharon N M.D.

ACCT #: K20034006872 LOC: S5E1
AGE/SX: 3Y 10M/F ROOM: S5517
STATUS: DIS IN BED: A

U #: K000629604
REG: 08/28/17
DIS: 08/30/17

Microbiology Specimen Summary

Col	Date	Time	Specimen #	Source	Sp Desc	P/F	Organisms ...
>	08/28/17	0137	174BC0030061S	Blood	Venipunct	F	<none>

Source: Blood

> Culture, Blood [REDACTED] Final 09/02/17
NO GROWTH AT 5 DAYS

> Culture, Blood [REDACTED] Preliminary (changed)
NO GROWTH AT 2 DAYS

** END OF REPORT **

Willis-Knighton South
2510 Bert Kouns Industrial Loop
Shreveport, LA 71118

Patient Name: [REDACTED]
Adm No: K20034006872
DOB: 10/01/2013
Age: 3Y F
Corp ID: 000001116206

MRN: 1116206
Location: Inpatient - S5E1-S5517A
Ord No: 90017
Hospital: WKS

Ordering Dr: EDWARD PAUL

CC: SHARON NHU TRAN

Final Report

Admitting Diagnosis: MILD PERSISTANT ASHTMA C STATUS ASTHMATICUS
Reason For Exam: Breathing Difficulty
Procedure Date: 08/28/2017
Procedure: SXR - XR, chest 1 view

Interpretive Location: WKN
Accession Number: 3759327
CPT Code: 71010

IMPRESSION: Normal chest.

RESULT:

Procedure: XR, chest 1 view

Clinical Information: Breathing Difficulty

Comparison: Chest radiograph from 7/15/2017

Findings:

Heart size and contour are within normal limits. The lungs are clear of infiltrate, mass, or effusion. No significant skeletal abnormality is noted.

Electronically Signed by: [REDACTED] JOSEPH BURGIN M.D. on Aug 28 2017 8:00A

Techs: Jose A Torres
Additional Staff:

Read by: [REDACTED] JOSEPH BURGIN M.D. on Aug 28 2017 7:55A
Electronically Signed by: [REDACTED] JOSEPH BURGIN M.D. on Aug 28 2017 8:00A

Printed: Aug 28 2017 8:04AM

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09/01/2017 00:05

DISCHARGE MEDICATION ADMINISTRATION RECORD
Willis-Knighton Health System

PAGE: 1 OF 6

PATIENT NO: K20034006872
MED REC NO: 1116206
SITE: WKSH

NAME: [REDACTED] L
AGE: 3Y DOB: 10/01/2013 SEX: F
ATN DOCTOR: TRAN, SHARON NHU MD

DSCH LOC: S5E1/S5517A
DSCH DATE: 08/30/2017
ADMIT DATE: 08/28/2017

*** MEDICATIONS CURRENT AT THE TIME OF DISCHARGE ***

*** SCHEDULED MEDICATIONS ***

ORD# 10
ALBUTEROL 0.083% 2.5 MG = 3 ML
(PROVENTIL 0.083%)
Q3H RT NEBULIZED EVERY THREE HOURS RT
START: 08/29/17 13:44 STOP: 09/28/17 03:16
Nrs Verified By: CLEWIS
08/29/17 17:08 ADMIN GGRISH at: 08/29/17 17:08
08/29/17 19:47 ADMIN FHUCKA at: 08/29/17 19:47
08/29/17 22:44 ADMIN FHUCKA at: 08/29/17 22:44
08/29/17 23:59 ADMIN TGREEN at: 08/29/17 23:59
08/30/17 04:03 ADMIN TGREEN at: 08/30/17 04:03
08/30/17 08:40 ADMIN STHAME at: 08/30/17 08:40
08/30/17 11:30 ADMIN STHAME at: 08/30/17 11:30

ORD# 10 (REVISED)
ALBUTEROL 0.083% 2.5 MG = 3 ML
(PROVENTIL 0.083%)
Q3H RT NEBULIZED EVERY THREE HOURS RT
START: 08/29/17 13:44 STOP: 08/30/17 11:47
Nrs Verified By: CLEWIS
**** NO OCCURRENCES CHARTED ****

ORD# 12
ALBUTEROL 0.083% 2.5 MG = 3 ML
(PROVENTIL 0.083%)
Q4H RT NEBULIZED EVERY FOUR HOURS RT
START: 08/30/17 11:49 STOP: 09/28/17 03:16
Nrs Verified By:
**** NO OCCURRENCES CHARTED ****

ORD# 12 (REVISED)
ALBUTEROL 0.083% 2.5 MG = 3 ML
(PROVENTIL 0.083%)
Q4H RT NEBULIZED EVERY FOUR HOURS RT
START: 08/30/17 11:49 STOP: 08/30/17 23:03
Nrs Verified By:
**** ORDER DISCONTINUED ****

ORD# 11
PREDNISOLONE 15 MG = 5 ML
(PRELONE *BKC*)
2XDAY ORAL TWO TIMES A DAY
START: 08/29/17 13:45 STOP: 09/29/17 09:00
Nrs Verified By: CLEWIS
08/29/17 13:45 ADMIN CLEWIS at: 08/29/17 14:44
08/29/17 21:00 ADMIN GKELLE at: 08/29/17 20:38
08/30/17 09:00 ADMIN AFORTI at: 08/30/17 08:52

ORD# 11 (REVISED)
PREDNISOLONE 15 MG = 5 ML
(PRELONE *BKC*)
2XDAY ORAL TWO TIMES A DAY
START: 08/29/17 13:45 STOP: 08/30/17 23:03
Nrs Verified By: CLEWIS
**** ORDER DISCONTINUED ****

<PERMANENT CHART COPY>

09/01/2017 00:05

DISCHARGE MEDICATION ADMINISTRATION RECORD
Willis-Knighton Health System

PAGE: 2 OF 6

PATIENT NO: K20034006872
MED REC NO: 1116206
SITE: WKSH

NAME: [REDACTED] L
AGE: 3Y DOB: 10/01/2013 SEX: F
ATN DOCTOR: TRAN, SHARON NHU MD

DSCH LOC: S5E1/S5517A
DSCH DATE: 08/30/2017
ADMIT DATE: 08/28/2017

*** MEDICATIONS CURRENT AT THE TIME OF DISCHARGE ***

*** PRN MEDICATIONS ***

ORD# 9
ACETAMINOPHEN 240 MG = 7.495 ML
(TYLENOL)
Q4H PRN ORAL EVERY 4 HOURS AS NEEDED
TEMP > 100.4F/PAIN
SHAKE WELL.
MAX ACETAMINOPHEN
DOSE: 4 G/24 HR.
START: 08/28/17 14:40 STOP: 09/28/17 14:39
Nrs Verified By: GKELLE
**** NO OCCURRENCES CHARTED ****

ORD# 9 (REVISED)
ACETAMINOPHEN 240 MG = 7.495 ML
(TYLENOL)
Q4H PRN ORAL EVERY 4 HOURS AS NEEDED
TEMP > 100.4F/PAIN
SHAKE WELL.
MAX ACETAMINOPHEN
DOSE: 4 G/24 HR.
START: 08/28/17 14:40 STOP: 08/30/17 23:03
Nrs Verified By: GKELLE
**** ORDER DISCONTINUED ****

ORD# 7
IBUPROFEN 160 MG = 8 ML
(PEDIA-PROFEN)
Q6H PRN ORAL EVERY 6 HOURS AS NEEDED
TEMP > 100.4 DEGREES F.
PRN TEMP GREATER THAN 100.4
SHAKE WELL.
MAX IBUPROFEN
DOSE: 3.2 G/24HR.
START: 08/28/17 04:36 STOP: 09/28/17 04:35
Nrs Verified By: MWALLA
**** NO OCCURRENCES CHARTED ****

ORD# 7 (REVISED)
IBUPROFEN 160 MG = 8 ML
(PEDIA-PROFEN)
Q6H PRN ORAL EVERY 6 HOURS AS NEEDED
TEMP > 100.4 DEGREES F.
PRN TEMP GREATER THAN 100.4
SHAKE WELL.
MAX IBUPROFEN
DOSE: 3.2 G/24HR.
START: 08/28/17 04:36 STOP: 08/30/17 23:03
Nrs Verified By: MWALLA
**** ORDER DISCONTINUED ****

*** ORDERS DISCONTINUED AT THE TIME OF DISCHARGE ***

*** MEDICATIONS ***

ORD# 3 (REVISED)
METHYLPREDNISOLONE 15 MG = 0.375 ML
(SOLU-MEDROL)
Q12H IV EVERY 12 HOURS
START: 08/28/17 13:30 STOP: 09/28/17 01:30
Nrs Verified By: MWALLA
08/28/17 13:30 ADMIN CLEWIS at: 08/28/17 13:43
08/29/17 01:30 ADMIN GKELLE at: 08/29/17 03:00
08/29/17 13:30 NOTADMIN CLEWIS at: 08/29/17 13:40
Charted Reason: No IV Access

<PERMANENT CHART COPY>

09/01/2017 00:05

DISCHARGE MEDICATION ADMINISTRATION RECORD
Willis-Knighton Health System

PAGE: 3 OF 6

PATIENT NO: K20034006872
MED REC NO: 1116206
SITE: WKSHNAME: [REDACTED] L
AGE: 3Y DOB: 10/01/2013 SEX: F
ATN DOCTOR: TRAN, SHARON NHU MDDSCH LOC: S5E1/S5517A
DSCH DATE: 08/30/2017
ADMIT DATE: 08/28/2017

*** ORDERS DISCONTINUED AT THE TIME OF DISCHARGE ***

*** MEDICATIONS ***

ORD# 3 (REVISED)
METHYLPREDNISOLONE
(SOLU-MEDROL)

15 MG = 0.375 ML

Q12H

IV

EVERY 12 HOURS

START: 08/28/17 13:30 STOP: 08/29/17 13:43

Nrs Verified By: MWALLA

**** NO OCCURRENCES CHARTED ****

ORD# 5 (REVISED)
IPRATROPIUM 0.02%
(ATROVENT 0.02%)

0.5 MG = 2.5 ML

Q6H RT

NEBULIZED

EVERY SIX HOURS RT

START: 08/28/17 03:17 STOP: 09/28/17 03:16

Nrs Verified By: MWALLA

08/28/17 05:00	ADMIN	CEARLE	at: 08/28/17 05:00
08/28/17 11:55	ADMIN	GGRISH	at: 08/28/17 11:55
08/28/17 18:03	ADMIN	GGRISH	at: 08/28/17 18:03
08/29/17 08:30	ADMIN	GGRISH	at: 08/29/17 08:30
08/29/17 13:14	ADMIN	GGRISH	at: 08/29/17 13:14

ORD# 5 (REVISED)
IPRATROPIUM 0.02%
(ATROVENT 0.02%)

0.5 MG = 2.5 ML

Q6H RT

NEBULIZED

EVERY SIX HOURS RT

START: 08/28/17 03:17 STOP: 08/29/17 13:43

Nrs Verified By: MWALLA

**** NO OCCURRENCES CHARTED ****

ORD# 6 (REVISED)
ALBUTEROL 0.083%
(PROVENTIL 0.083%)

2.5 MG = 3 ML

Q2H RT

NEBULIZED

EVERY TWO HOURS RT

START: 08/28/17 03:17 STOP: 09/28/17 03:16

Nrs Verified By: MWALLA

08/28/17 05:00	ADMIN	CEARLE	at: 08/28/17 05:00
08/28/17 07:25	ADMIN	GGRISH	at: 08/28/17 07:25
08/28/17 09:20	ADMIN	GGRISH	at: 08/28/17 09:20
08/28/17 11:55	ADMIN	GGRISH	at: 08/28/17 11:55
08/28/17 13:47	ADMIN	GGRISH	at: 08/28/17 13:47
08/28/17 16:15	ADMIN	GGRISH	at: 08/28/17 16:15
08/28/17 18:03	ADMIN	GGRISH	at: 08/28/17 18:03
08/28/17 20:27	ADMIN	TGREEN	at: 08/28/17 20:27
08/28/17 22:05	ADMIN	TGREEN	at: 08/28/17 22:05
08/29/17 03:54	ADMIN	TGREEN	at: 08/29/17 03:54
08/29/17 05:54	ADMIN	TGREEN	at: 08/29/17 05:54
08/29/17 08:30	ADMIN	GGRISH	at: 08/29/17 08:30
08/29/17 10:32	ADMIN	GGRISH	at: 08/29/17 10:32
08/29/17 13:14	ADMIN	GGRISH	at: 08/29/17 13:14

ORD# 6 (REVISED)
ALBUTEROL 0.083%
(PROVENTIL 0.083%)

2.5 MG = 3 ML

Q2H RT

NEBULIZED

EVERY TWO HOURS RT

START: 08/28/17 03:17 STOP: 08/29/17 13:43

Nrs Verified By: MWALLA

**** NO OCCURRENCES CHARTED ****

<PERMANENT CHART COPY>

09/01/2017 00:05

DISCHARGE MEDICATION ADMINISTRATION RECORD
Willis-Knighton Health System

PAGE: 4 OF 6

PATIENT NO: K20034006872
MED REC NO: 1116206
SITE: WKSHNAME: [REDACTED] L
AGE: 3Y DOB: 10/01/2013 SEX: F
ATN DOCTOR: TRAN, SHARON NHU MDDSCH LOC: S5E1/S5517A
DSCH DATE: 08/30/2017
ADMIT DATE: 08/28/2017

*** ORDERS DISCONTINUED AT THE TIME OF DISCHARGE ***

*** MEDICATIONS ***

ORD# 4
IBUPROFEN 160 MG = 8 ML
(PEDIA-PROFEN)
Q6H ORAL EVERY 6 HOURS
PRN TEMP GREATER THAN 100.4
SHAKE WELL.
MAX IBUPROFEN
DOSE: 3.2 G/24HR.
START: 08/28/17 03:30 STOP: 09/27/17 21:30
Nrs Verified By:
**** NO OCCURRENCES CHARTED ****

ORD# 4 (REVISED)
IBUPROFEN 160 MG = 8 ML
(PEDIA-PROFEN)
Q6H ORAL EVERY 6 HOURS
PRN TEMP GREATER THAN 100.4
SHAKE WELL.
MAX IBUPROFEN
DOSE: 3.2 G/24HR.
START: 08/28/17 03:30 STOP: 08/28/17 04:36
Nrs Verified By: MWALLA
**** ORDER DISCONTINUED ****

*** IVS ***

ORD# 1 UB: A
LVP LARGE VOLUME PARENTERAL
SODIUM CHLORIDE 0.9% 50 ml
MAGNESIUM SULFATE 50% 850 MG = 1.7 ML
(MAGNESIUM SULFATE 50%)
IV
RATE: 155 ml/hr RUN-IN: 0.33 hrs
START: 08/28/17 01:53 STOP: 08/28/17 02:13
Nrs Verified By: MWALLA
**** NO OCCURRENCES CHARTED ****

ORD# 2 (REVISED) UB: A
LVP LARGE VOLUME PARENTERAL
KCL 20 MEQ/D5W-0.45%NS 1000ML 20 MEQ = 1000 ML
IV CONTINUOUS CONTINUOUS
RATE: 55 ml/hr RUN-IN: 18.25 hrs
START: 08/28/17 03:22 STOP: 08/31/17 03:21
Nrs Verified By: MWALLA
08/28/17 04:31 ADMIN MWALLA at: 08/28/17 04:31

ORD# 2 (REVISED) UB: A
LVP LARGE VOLUME PARENTERAL
KCL 20 MEQ/D5W-0.45%NS 1000ML 20 MEQ = 1000 ML
IV CONTINUOUS CONTINUOUS
RATE: 55 ml/hr RUN-IN: 18.25 hrs
START: 08/28/17 03:22 STOP: 08/28/17 14:36
Nrs Verified By: MWALLA
**** NO OCCURRENCES CHARTED ****

ORD# 8 UB: A
LVP LARGE VOLUME PARENTERAL
KCL 20 MEQ/D5W-0.45%NS 1000ML 20 MEQ = 1000 ML
IV CONTINUOUS CONTINUOUS
RATE: 35 ml/hr RUN-IN: 28.58 hrs
START: 08/28/17 14:30 STOP: 08/31/17 03:21
Nrs Verified By: GKELLE
08/28/17 23:03 ADMIN GKELLE at: 08/28/17 23:03

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09/01/2017 00:05

DISCHARGE MEDICATION ADMINISTRATION RECORD
Willis-Knighton Health System

PAGE: 5 OF 6

PATIENT NO: K20034006872
MED REC NO: 1116206
SITE: WKSH

NAME: [REDACTED] L
AGE: 3Y DOB: 10/01/2013 SEX: F
ATN DOCTOR: TRAN, SHARON NHU MD

DSCH LOC: S5E1/S5517A
DSCH DATE: 08/30/2017
ADMIT DATE: 08/28/2017

*** ORDERS DISCONTINUED AT THE TIME OF DISCHARGE ***

*** IVS ***

ORD# 8 (REVISED) UB: A
LVP LARGE VOLUME PARENTERAL
KCL 20 MEQ/D5W-0.45%NS 1000ML 20 MEQ = 1000 ML
IV CONTINUOUS CONTINUOUS
RATE: 35 ml/hr RUN-IN: 28.58 hrs
START: 08/28/17 14:30 STOP: 08/29/17 13:43
Nrs Verified By: GKELLE
**** NO OCCURRENCES CHARTED ****

<PERMANENT CHART COPY>

09/01/2017 00:05

DISCHARGE MEDICATION ADMINISTRATION RECORD
Willis-Knighton Health System

PAGE: 6 OF 6

PATIENT NO: K20034006872
MED REC NO: 1116206
SITE: WKSH

NAME: [REDACTED] L
AGE: 3Y DOB: 10/01/2013 SEX: F
ATN DOCTOR: TRAN, SHARON NHU MD

DSCH LOC: S5E1/S5517A
DSCH DATE: 08/30/2017
ADMIT DATE: 08/28/2017

*** NURSE IDENTIFICATION ***

AFORTI Fortiz, Amanda RN
CEARLE Earley, Chad RT
CLEWIS Lewis, Catrina RN
FHUCKA Huckabee, Fredda RT
GGRISH Grisham, Gentry RT
GKELLE Kelley, Gwendolyn RN
MWALLA Wallace, Meghan RN
STHAME Thames, Shannon RT
TGREEN Greene, Tashanna RT

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RUN DATE: (/17 lllis Knightor th *ADMISSIO
RUN TIME: 0127 INTERDISCIPLINARY ALLERGY SOURCE DOCUMENT
RUN USER: PATERA.AM

PAGE 1

Name: L DOB: 10/01/13 Age: 3Y 10M
Rm/Bd: Serv/Loen: ERS Status: ER Sex: F
Unit#: K000629604 Account#: K20034006872 EPI#: 000000001116206

Last Update/
Acknowledgement:

Interdisciplinary Assessment (Free Text), historical data:

Allergy1-Med/Contact: NKDA	11/04/16 - 2201
Allergy2-Med/Contact: NKDA	11/04/16 - 2201
Food Allergies-Intol: NKFA	11/04/16 - 2201
Latex Allergy (Y/N): N	11/04/16 - 2201

Pharmacy Allergy List (Coded Allergies), historical data:
(Duplicate names represent coding within (3) categories:
Ingredient, Generic and Class allergy codes.)

11/06/16

NO KNOWN DRUG ALLERGIES, NO KNOWN FOOD ALLERGIES, NO KNOWN LATEX ALLERGY

Interdisciplinary Allergy Source Document is a Permanent Part of
the Patient's Medical Record

ACLS/PALS Results

Page 1 of 5

Dosing Calculators - Emergency Drugs

Select Dosing Type:

☒ Pediatric ☐ Adult

Patient Weight:

16.78 ☒ kg ☐ lb

Results: [Mon Aug 28 09:03:26 GMT 2017]

*yellow***Pediatric Emergency Drug Dosing Calculator**

This calculator is intended to calculate dosing for pediatric patients aged 29 days or older; it is not intended for dosing of neonates. As with all MICROMEDEX products, please use caution and exercise your clinical discretion and professional judgment when utilizing this calculator.

Mon Aug 28 09:03:26 GMT 2017

Patient Name: [REDACTED] A

Entered Values: Dosing Type: Pediatric Patient Weight: 16.8 kg (36.9 lb)

Recommendations according to AHA guidelines ACLS/PALS resuscitation.

*Attention - Institutionally dispensed drug concentrations may vary.

Drug	Route	Dose	Delivery
Adenosine			
Initial: 0.1 mg/kg/dose MAX: 6 mg/dose Repeat: 0.2 mg/kg/dose MAX: 12 mg/dose	Rapid IV/IO Push	1.68 mg/dose (0.56 mL/dose of 3 mg/mL conc) MAX: 6 mg/dose Repeat: 3.36 mg/dose (1.12 mL/dose of 3 mg/mL conc) MAX: 12 mg/dose	Immediately follow drug administration with at least 5 mL normal saline.
Amiodarone			
5 mg/kg/dose MAX: 300 mg/dose May repeat dose twice up to MAX: 15 mg/kg	IV/IO	84 mg/dose (1.68 mL/dose of a 50 mg/mL conc) for pulseless VT/VF, give as rapid bolus; for perfusing tachycardias, infuse over 20 to 60 minutes MAX: 300 mg/dose May repeat dose twice up to MAX: 252 mg	Dilute to 1 to 6 mg/mL in D5W.

ACLS/P... Results

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Drug	Route	Dose	Delivery
Atropine			
IV: 0.02 mg/kg/dose MAX: 0.5 mg/dose May repeat once	IV/IO	0.34 mg/dose (3.36 mL/dose of 0.1 mg/mL conc) MAX: 0.5 mg May repeat once	
ET: 0.04 to 0.06 mg/kg/dose MAX: 0.5 mg/dose May repeat once	ET	0.5 mg/dose (0.5 mL/dose of 1 mg/mL conc) Dose based on 0.04 mg/kg/dose MAX: 0.5 mg May repeat once	Dilute in NS to a volume of 5 mL and follow instillation by 5 positive pressure ventilations via ambu-bag.
Calcium chloride 10%			
20 mg/kg/dose MAX: 2 g/dose	Slow IV/IO	336 mg/dose (3.4 mL/dose of 100 mg/mL conc) MAX: 2 g/dose	Administer slowly.
Cardioversion			
0.5 to 1 joule/kg May Repeat 2 joules/kg	Electrical	8.4 joules Dose based on: 0.5 joules/kg May Repeat 34 joules	
Defibrillation			
Initial shock: 2 joules/kg Second shock: 4 joules/kg	Electrical	Initial shock: 33.56 joules Second shock: 67.12 joules	Subsequent shocks of 4 joules/kg or more up to a MAX: 10 joules/kg or adult dose, whichever is less.
Dextrose			
0.5 to 1 g/kg MAX: 25 g	IV/IO	8.4 g/dose (34 mL/dose of D25W) Dose based on: 0.5 g/kg MAX: 25 g	Infants and children: Use D25W. May dilute D50W 1:1 with sterile water to make D25W prior to administration. Adolescents: Use D50W.

ACLS/P... Results

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Drug	Route	Dose	Delivery
DOBUTamine hydrochloride			
2 to 20 mcg/kg/min	IV/IO	Starting dose: 83.9 mcg/min (5 mL/hr of a 1000 mcg/mL conc) Dose based on: 5 mcg/kg/min	Mix 20 mL from a 12.5 mg/mL vial in 250 mL D5W for a 1000 mcg/mL solution.
DOPamine			
2 to 20 mcg/kg/min	IV/IO	Starting dose: 83.9 mcg/min (3.1 mL/hr of a 1600 mcg/mL conc) Dose based on: 5 mcg/kg/min	Mix 10 mL from a 40 mg/mL vial in 250 mL D5W for a 1600 mcg/mL solution.
EPINEPHrine			
IV: 0.01 mg/kg MAX: 1 mg/dose May Repeat every 3 to 5 minutes	IV/IO	0.17 mg/dose (1.7 mL/dose of a 0.1 mg/mL conc) MAX: 1 mg/dose May repeat every 3 to 5 minutes	
ET: 0.1 mg/kg MAX: 2.5 mg/dose May repeat every 3 to 5 minutes	ET	1.7 mg/dose (1.7 mL/dose of a 1 mg/mL conc) MAX: 2.5 mg/dose May repeat every 3 to 5 minutes	Dilute in NS to a volume of 5 mL and follow instillation by 5 positive pressure ventilation via ambu-bag.
EPINEPHrine: Infusion			
0.1 to 1 mcg/kg/min	Infusion	Starting Dose: 1.68 mcg/min (2 mL/hr of a 50 mcg/mL conc) Dose based on 0.1 mcg/kg/min	Mix 12.5 mL of 1 mg/mL vial in 250 mL D5W for a 50 mcg/mL solution.

ACLS/PALS Results

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Drug	Route	Dose	Delivery
Lidocaine			
IV: 1 mg/kg/dose MAX: 100 mg Repeat bolus if infusion not started within 15 minutes of initial bolus.	IV/IO	17 mg/dose (1.7 mL/dose of 10 mg/mL conc) MAX: 100 mg Repeat bolus if infusion not started within 15 minutes of initial bolus.	
ET: 2 to 3 mg/kg/dose	ET	34 mg/dose (3.4 mL/dose of 10 mg/mL conc) Dose based on 2 mg/kg/dose	Dilute in NS to a volume of 5 mL and follow instillation by 5 positive pressure ventilation via ambu-bag.
Infusion: 20 to 50 mcg/kg/min	Infusion	336 mcg/min (8.4 mL/hr of a 2400 mcg/mL conc) Dose based on 20 mcg/kg/min	Mix 30 mL from a 20 mg/mL vial in 250 mL D5W for a 2400 mcg/mL solution.
Magnesium sulfate			
25 to 50 mg/kg/dose MAX: 2 g/dose	IV/IO	420 mg/dose (0.8 mL/dose of 500 mg/mL conc) over 10 to 20 minutes, faster in torsades de pointes MAX: 2 g/dose Dose based on 25 mg/kg/dose	Dilute to a MAX of 200 mg/mL.
Naloxone For Full Reversal			
IV: younger than 5 years old or 20 kg or less: 0.1 mg/kg/dose MAX: 2 mg/dose 5 years and older or more than 20 kg: 2 mg/dose	IV/IO/ET	For Full Reversal: younger than 5 years old or 20 kg or less: 1.68 mg/dose (1.7 mL/dose of 1 mg/mL conc) MAX: 2 mg/dose 5 years and older or more than 20 kg: 2 mg/dose	For ET administration: May require 2 to 3 times IV dose. Dilute ET dose in NS to a volume of 5 mL and follow instillation by 5 positive pressure ventilations via ambu-bag. Use lower doses to reverse respiratory depression associated with therapeutic opioid use (1 to 5 mcg/kg titrate to effect).

ACLS/P. Results

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Drug	Route	Dose	Delivery
Procainamide			
15 mg/kg/dose	IV/IO	252 mg/dose (2.52 mL/dose of 100 mg/mL conc) infuse over 30 to 60 minutes	Dilute in NS to a conc of 20 mg/mL. Monitor ECG and blood pressure. Use caution when administering with other drugs that prolong QA.
Sodium bicarbonate			
1 mEq/kg/dose	IV/IO	17 mEq/dose (17 mL/dose of 1 mEq/mL conc)	After adequate ventilation.

Willis Knighton Respiratory

Account: K20034006872	Physician Name:	Admit Date: 8/28/2017 3:07:00 AM
First Name: [REDACTED]	MRN: 1116206	Discharge Date:
Last Name: [REDACTED]	Date of Birth: 10/01/2013	Charting Category: MEDTX
Charting Template: Treatment Note	Charting Date: 8/30/2017 11:30:00 AM	Charting ID: 1000999873

Heart Rate: 17 beats per minute
Respiratory Rate: 22 breaths per minute
All Lung Fields: Clear
Work of Breathing: No use of accessory muscles noted.
PAIN: No pain communicated or visualized by respiratory therapy at this time.

Interventions:
MEDICATION THERAPY: Small volume nebulizer treatment given via face mask for pediatric patient, with Albuterol 0.083% (2.5 mg/3 mL)
Treatment delivered via oxygen.

The patient had no adverse effects.

Post Therapy Assessment:
Heart Rate: 116 beats per minute
Respiratory Rate: 20 breaths per minute
Breath Sounds:
All Lung Fields: Diminished
Work of Breathing: No use of accessory muscles noted.
Cough/Suction: Patient had no cough at this time.

Education:
No education was provided at this time.

Electronically Signed By: Shannon Thames, CRT on 08/30/2017 at 11:33

Willis Knighton Respiratory

Account: K20034006872	Physician Name:	Admit Date: 8/28/2017 3:07:00 AM
First Name: [REDACTED]	MRN: 1116206	Discharge Date:
Last Name: [REDACTED]	Date of Birth: 10/01/2013	Charting Category: MEDTX
Charting Template: Treatment Note	Charting Date: 8/30/2017 8:40:00 AM	Charting ID: 1000999606

Heart Rate: 21 beats per minute
Respiratory Rate: 20 breaths per minute
All Lung Fields: Coarse
Work of Breathing: No use of accessory muscles noted.
PAIN: No pain communicated or visualized by respiratory therapy at this time.

Interventions:
MEDICATION THERAPY: Small volume nebulizer treatment given via face mask for pediatric patient, with Albuterol 0.083% (2.5 mg/3 mL)
Treatment delivered via oxygen.

The patient had no adverse effects.

Post Therapy Assessment:
Heart Rate: 118 beats per minute
Respiratory Rate: 20 breaths per minute
Breath Sounds:
All Lung Fields: Coarse
Work of Breathing: No use of accessory muscles noted.
Cough/Suction: Patient had a strong non-productive cough.

Education:
No education was provided at this time.

Electronically Signed By: Shannon Thames, CRT on 08/30/2017 at 08:43

Willis Knighton Respiratory

Account: K20034006872	Physician Name:	Admit Date: 8/28/2017 3:07:00 AM
First Name: [REDACTED]	MRN: 1116206	Discharge Date:
Last Name: [REDACTED]	Date of Birth: 10/01/2013	Charting Category: MEDTX
Charting Template: Treatment Note	Charting Date: 8/30/2017 4:00:00 AM	Charting ID: 1000999324

Heart Rate: 60 beats per minute
Respiratory Rate: 20 breaths per minute
All Lung Fields: Coarse
Work of Breathing: No use of accessory muscles noted.
PAIN: No pain communicated or visualized by respiratory therapy at this time.

Interventions:
MEDICATION THERAPY: Small volume nebulizer treatment given via face mask for pediatric patient, with Albuterol 0.083% (2.5 mg/3 mL)
Treatment delivered via oxygen.

The patient had no adverse effects.

Post Therapy Assessment:
Heart Rate: 66 beats per minute
Respiratory Rate: 20 breaths per minute
Breath Sounds:
All Lung Fields: Coarse
Work of Breathing: No use of accessory muscles noted.
Cough/Suction: Patient had no cough at this time.

Education:
No education was provided at this time.

Electronically Signed By: Tashanna Greene, on 08/30/2017 at 04:09

Willis Knighton Respiratory

Account: K20034006872	Physician Name:	Admit Date: 8/28/2017 3:07:00 AM
First Name: [REDACTED]	MRN: 1116206	Discharge Date:
Last Name: [REDACTED]	Date of Birth: 10/01/2013	Charting Category: MEDTX
Charting Template: Treatment Note	Charting Date: 8/30/2017 12:01:00 AM	Charting ID: 1000999059

Heart Rate: 64 beats per minute
Respiratory Rate: 20 breaths per minute
All Lung Fields: Rhonchi/Coarse crackles
Work of Breathing: No use of accessory muscles noted.
PAIN: No pain communicated or visualized by respiratory therapy at this time.

Interventions:

MEDICATION THERAPY: Small volume nebulizer treatment given via face mask for pediatric patient, with Albuterol 0.083% (2.5 mg/3 mL).
Treatment delivered via oxygen.

The patient had no adverse effects.

Post Therapy Assessment:

Heart Rate: 66 beats per minute
Respiratory Rate: 22 breaths per minute
Breath Sounds:
All Lung Fields: Rhonchi/Coarse crackles
Work of Breathing: No use of accessory muscles noted.
Cough/Suction: Patient had no cough at this time.

Education:

No education was provided at this time.

Electronically Signed By: Tashanna Greene, on 08/30/2017 at 00:02

Willis Knighton Respiratory

Account: K20034006872	Physician Name:	Admit Date: 8/28/2017 3:07:00 AM
First Name: [REDACTED]	MRN: 1116206	Discharge Date:
Last Name: [REDACTED]	Date of Birth: 10/01/2013	Charting Category: MEDTX
Charting Template: Treatment Note	Charting Date: 8/29/2017 10:45:00 PM	Charting ID: 1000998943

Heart Rate: 82 beats per minute
Respiratory Rate: 20 breaths per minute
All Lung Fields: Clear
Work of Breathing: No use of accessory muscles noted.
PAIN: No pain communicated or visualized by respiratory therapy at this time.

Interventions:
MEDICATION THERAPY: Small volume nebulizer treatment given via face mask for pediatric patient, with Albuterol 0.083% (2.5 mg/3 mL)
Treatment delivered via oxygen.

The patient had no adverse effects.

Post Therapy Assessment:
Heart Rate: 84 beats per minute
Respiratory Rate: 20 breaths per minute
Breath Sounds:
All Lung Fields: Clear
Work of Breathing: No use of accessory muscles noted.
Cough/Suction: Patient had no cough at this time.

Education:
Informal: Indications, possible side effects, expected outcomes of therapy and/or current status were explained.

Electronically Signed By: Fredda Huckabee, RRT on 08/29/2017 at 22:54

Willis Knighton Respiratory

Account: K20034006872	Physician Name:	Admit Date: 8/28/2017 3:07:00 AM
First Name: [REDACTED]	MRN: 1116206	Discharge Date:
Last Name: [REDACTED]	Date of Birth: 10/01/2013	Charting Category: MEDTX
Charting Template: Treatment Note	Charting Date: 8/29/2017 7:45:00 PM	Charting ID: 1000998694

Heart Rate: 122 beats per minute
Respiratory Rate: 24 breaths per minute
All Lung Fields: Clear
Work of Breathing: No use of accessory muscles noted.
PAIN: No pain communicated or visualized by respiratory therapy at this time.

Interventions:
MEDICATION THERAPY: Small volume nebulizer treatment given via face mask for pediatric patient, with Albuterol 0.083% (2.5 mg/3 mL)
Treatment delivered via oxygen.

The patient had no adverse effects.

Post Therapy Assessment:
Heart Rate: 120 beats per minute
Respiratory Rate: 20 breaths per minute
Breath Sounds:
All Lung Fields: Clear
Work of Breathing: No use of accessory muscles noted.
Cough/Suction: Patient had no cough at this time.

Education:
Informal: Indications, possible side effects, expected outcomes of therapy and/or current status were explained.

Electronically Signed By: Fredda Huckabee, RRT on 08/29/2017 at 19:55

Willis Knighton Respiratory

Account: K20034006872	Physician Name:	Admit Date: 8/28/2017 3:07:00 AM
First Name: [REDACTED]	MRN: 1116206	Discharge Date:
Last Name: [REDACTED]	Date of Birth: 10/01/2013	Charting Category: MEDTX
Charting Template: Treatment Note	Charting Date: 8/29/2017 8:30:00 AM	Charting ID: 1000997766

Heart Rate: 148 beats per minute
Respiratory Rate: 20 breaths per minute
All Lung Fields: Clear
Work of Breathing: No use of accessory muscles noted.
PAIN: No pain communicated or visualized by respiratory therapy at this time.

Interventions:
MEDICATION THERAPY: Small volume nebulizer treatment given via mouth piece with Atrovent (Ipratropium Bromide) 0.02% (0.5 mg/2.5 mL)/Albuterol 0.083% Unit Dose (2.5 mg/3 mL) Treatment delivered via oxygen.

The patient had no adverse effects.

Post Therapy Assessment:
Heart Rate: 150 beats per minute
Respiratory Rate: 18 breaths per minute
Breath Sounds:
All Lung Fields: Clear
Work of Breathing: No use of accessory muscles noted.
Cough/Suction: Patient had a strong non-productive cough.

Education:
Informal: Indications, possible side effects, expected outcomes of therapy and/or current status were explained.

Electronically Signed By: Gentry Grisham, RRT on 08/29/2017 at 08:35

Willis Knighton Respiratory

Account: K20034006872	Physician Name:	Admit Date: 8/28/2017 3:07:00 AM
First Name: [REDACTED]	MRN: 1116206	Discharge Date:
Last Name: [REDACTED]	Date of Birth: 10/01/2013	Charting Category: MEDTX
Charting Template: Treatment Note	Charting Date: 8/29/2017 5:00:00 PM	Charting ID: 1000998494

Heart Rate: 130 beats per minute
Respiratory Rate: 18 breaths per minute
All Lung Fields: Clear
Work of Breathing: No use of accessory muscles noted.
PAIN: No pain communicated or visualized by respiratory therapy at this time.

Interventions:
MEDICATION THERAPY: Small volume nebulizer treatment given via face mask for pediatric patient, with Albuterol 0.083% (2.5 mg/3 mL)
Treatment delivered via oxygen.

The patient had no adverse effects.

Post Therapy Assessment:
Heart Rate: 130 beats per minute
Respiratory Rate: 20 breaths per minute
Breath Sounds:
All Lung Fields: Clear
Work of Breathing: No use of accessory muscles noted.
Cough/Suction: Patient had a strong non-productive cough.

Education:
No education was provided at this time.

Electronically Signed By: Gentry Grisham, RRT on 08/29/2017 at 17:10

Willis Knighton Respiratory

Account: K20034006872	Physician Name:	Admit Date: 8/28/2017 3:07:00 AM
First Name: [REDACTED]	MRN: 1116206	Discharge Date:
Last Name: [REDACTED]	Date of Birth: 10/01/2013	Charting Category: MEDTX
Charting Template: Treatment Note	Charting Date: 8/29/2017 1:14:00 PM	Charting ID: 1000998155

Heart Rate: 140 beats per minute
Respiratory Rate: 22 breaths per minute
All Lung Fields: Clear
Work of Breathing: No use of accessory muscles noted.
PAIN: No pain communicated or visualized by respiratory therapy at this time.

Interventions:
MEDICATION THERAPY: Small volume nebulizer treatment given via face mask for pediatric patient, with Albuterol 0.083% (2.5 mg/3 mL)/
Atrovent (Ipratropium Bromide) 0.02% Unit Dose (0.5 mg/2.5 mL) Treatment delivered via oxygen.

The patient had no adverse effects.

Post Therapy Assessment:
Heart Rate: 130 beats per minute
Respiratory Rate: 20 breaths per minute
Breath Sounds:
All Lung Fields: Clear
Work of Breathing: No use of accessory muscles noted.
Cough/Suction: Patient had a strong non-productive cough.

Education:
No education was provided at this time.

Electronically Signed By: Gentry Grisham, RRT on 08/29/2017 at 13:19

Willis Knighton Respiratory

Account: K20034006872	Physician Name:	Admit Date: 8/28/2017 3:07:00 AM
First Name: [REDACTED]	MRN: 1116206	Discharge Date:
Last Name: [REDACTED]	Date of Birth: 10/01/2013	Charting Category: MEDTX
Charting Template: Treatment Note	Charting Date: 8/29/2017 10:32:00 AM	Charting ID: 1000997912

Heart Rate: 99 beats per minute
Respiratory Rate: 25 breaths per minute
All Lung Fields: Clear
Work of Breathing: No use of accessory muscles noted.
PAIN: No pain communicated or visualized by respiratory therapy at this time.

Interventions:
MEDICATION THERAPY: Small volume nebulizer treatment given via face mask for pediatric patient, with Albuterol 0.083% (2.5 mg/3 mL).
Treatment delivered via oxygen.

The patient had no adverse effects.

Post Therapy Assessment:
Heart Rate: 99 beats per minute
Respiratory Rate: 22 breaths per minute
Breath Sounds:
All Lung Fields: Clear
Work of Breathing: No use of accessory muscles noted.
Cough/Suction: Patient had a strong non-productive cough.

Education:
No education was provided at this time.

Electronically Signed By: Gentry Grisham, RRT on 08/29/2017 at 10:38

Willis Knighton Respiratory

Account: K20034006872	Physician Name:	Admit Date: 8/28/2017 3:07:00 AM
First Name: [REDACTED]	MRN: 1116206	Discharge Date:
Last Name: [REDACTED]	Date of Birth: 10/01/2013	Charting Category: MEDTX
Charting Template: Treatment Note	Charting Date: 8/29/2017 8:30:00 AM	Charting ID: 1000997766

Heart Rate: 148 beats per minute
Respiratory Rate: 20 breaths per minute
All Lung Fields: Clear
Work of Breathing: No use of accessory muscles noted.
PAIN: No pain communicated or visualized by respiratory therapy at this time.

Interventions:
MEDICATION THERAPY: Small volume nebulizer treatment given via face mask for pediatric patient, with Albuterol 0.083% (2.5 mg/3 mL)
Treatment delivered via oxygen.

The patient had no adverse effects.

Post Therapy Assessment:
Heart Rate: 150 beats per minute
Respiratory Rate: 18 breaths per minute
Breath Sounds:
All Lung Fields: Clear
Work of Breathing: No use of accessory muscles noted.
Cough/Suction: Patient had a strong non-productive cough.

Education:
Informal: Indications, possible side effects, expected outcomes of therapy and/or current status were explained.

Electronically Signed By: Gentry Grisham, RRT on 08/29/2017 at 08:35

Willis Knighton Respiratory

Account: K20034006872	Physician Name:	Admit Date: 8/28/2017 3:07:00 AM
First Name: [REDACTED]	MRN: 1116206	Discharge Date:
Last Name: [REDACTED]	Date of Birth: 10/01/2013	Charting Category: MEDTX
Charting Template: Treatment Note	Charting Date: 8/29/2017 6:00:00 AM	Charting ID: 1000997551

Heart Rate: 112 beats per minute
Respiratory Rate: 25 breaths per minute
All Lung Fields: Diminished
Work of Breathing: No use of accessory muscles noted.
PAIN: No pain communicated or visualized by respiratory therapy at this time.

Interventions:
MEDICATION THERAPY: Small volume nebulizer treatment given via face mask for pediatric patient, with Albuterol 0.083% (2.5 mg/3 mL)
Treatment delivered via oxygen.

The patient had no adverse effects.

Post Therapy Assessment:
Heart Rate: 112 beats per minute
Respiratory Rate: 25 breaths per minute
Breath Sounds:
All Lung Fields: Diminished
Work of Breathing: No use of accessory muscles noted.
Cough/Suction: Patient had no cough at this time.

Education:
No education was provided at this time.

Electronically Signed By: Tashanna Greene, on 08/29/2017 at 06:06

Willis Knighton Respiratory

Account: K20034006872	Physician Name:	Admit Date: 8/28/2017 3:07:00 AM
First Name: [REDACTED]	MRN: 1116206	Discharge Date:
Last Name: [REDACTED]	Date of Birth: 10/01/2013	Charting Category: MEDTX
Charting Template: Treatment Note	Charting Date: 8/29/2017 3:50:00 AM	Charting ID: 1000997497

Heart Rate: 105 beats per minute
Respiratory Rate: 22 breaths per minute
All Lung Fields: Coarse
Work of Breathing: No use of accessory muscles noted.
PAIN: No pain communicated or visualized by respiratory therapy at this time.

Interventions:
MEDICATION THERAPY: Small volume nebulizer treatment given via face mask for pediatric patient, with Albuterol 0.083% (2.5 mg/3 mL)
Treatment delivered via oxygen.

The patient had no adverse effects.

Post Therapy Assessment:
Heart Rate: 106 beats per minute
Respiratory Rate: 22 breaths per minute
Breath Sounds:
All Lung Fields: Diminished
Work of Breathing: No use of accessory muscles noted.
Cough/Suction: Patient had no cough at this time.

Education:
No education was provided at this time.

Electronically Signed By: Tashanna Greene, on 08/29/2017 at 03:58

Willis Knighton Respiratory

Account: K20034006872	Physician Name:	Admit Date: 8/28/2017 3:07:00 AM
First Name: [REDACTED]	MRN: 1116206	Discharge Date:
Last Name: [REDACTED]	Date of Birth: 10/01/2013	Charting Category: MEDTX
Charting Template: Treatment Note	Charting Date: 8/29/2017 2:00:00 AM	Charting ID: 1000997388

Heart Rate: 100 beats per minute
Respiratory Rate: 22 breaths per minute
All Lung Fields: Coarse
Work of Breathing: No use of accessory muscles noted.
PAIN: No pain communicated or visualized by respiratory therapy at this time.

Interventions:

MEDICATION THERAPY: Small volume nebulizer treatment given via face mask for pediatric patient, with Albuterol 0.083% (2.5 mg/3 mL)
Treatment delivered via oxygen.

The patient had no adverse effects.

Post Therapy Assessment:

Heart Rate: 108 beats per minute
Respiratory Rate: 24 breaths per minute
Breath Sounds:
All Lung Fields: Coarse
Work of Breathing: No use of accessory muscles noted.
Cough/Suction: Patient had no cough at this time.

Education:

No education was provided at this time.

Electronically Signed By: Tashanna Greene, on 08/29/2017 at 02:01

Willis Knighton Respiratory

Account: K20034006872	Physician Name:	Admit Date: 8/28/2017 3:07:00 AM
First Name: [REDACTED]	MRN: 1116206	Discharge Date:
Last Name: [REDACTED]	Date of Birth: 10/01/2013	Charting Category: MEDTX
Charting Template: Treatment Note	Charting Date: 8/29/2017 12:20:00 AM	Charting ID: 1000997327

Heart Rate: 118 beats per minute
Respiratory Rate: 19 breaths per minute
All Lung Fields: Diminished
Work of Breathing: No use of accessory muscles noted.
PAIN: No pain communicated or visualized by respiratory therapy at this time.

Interventions:
MEDICATION THERAPY: Small volume nebulizer treatment given via face mask for pediatric patient, with Albuterol 0.083% (2.5 mg/3 mL)/
Atrovent (Ipratropium Bromide) 0.02% Unit Dose (0.5 mg/2.5 mL) Treatment delivered via oxygen.

The patient had no adverse effects.

Post Therapy Assessment:
Heart Rate: 119 beats per minute
Respiratory Rate: 19 breaths per minute
Breath Sounds:
All Lung Fields: Diminished
Work of Breathing: No use of accessory muscles noted.
Cough/Suction: Patient had no cough at this time.

Education:
No education was provided at this time.

Electronically Signed By: Tashanna Greene, on 08/29/2017 at 00:20

Willis Knighton Respiratory

Account: K20034006872	Physician Name:	Admit Date: 8/28/2017 3:07:00 AM
First Name: [REDACTED]	MRN: 1116206	Discharge Date: 8/30/2017 3:00:00 PM
Last Name: [REDACTED]	Date of Birth: 10/01/2013	Charting Category: MEDGAS-SAT
Charting Template: Oxygen Therapy-Oximetry Note	Charting Date: 8/28/2017 5:05:00 AM	Charting ID: 1001000847

Pediatric Oxygen Protocol

Room Air SpO2 = 96 %. Oxygen not set up per protocol.

Electronically Signed By: Chad Earley, RRT on 08/31/2017 at 00:49

Willis Knighton Respiratory

Account: K20034006872	Physician Name:	Admit Date: 8/28/2017 3:07:00 AM
First Name: [REDACTED]	MRN: 1116206	Discharge Date:
Last Name: [REDACTED]	Date of Birth: 10/01/2013	Charting Category: MEDTX
Charting Template: Treatment Note	Charting Date: 8/28/2017 9:59:00 PM	Charting ID: 1000997128

Heart Rate: 112 beats per minute
Respiratory Rate: 20 breaths per minute
All Lung Fields: Diminished
Work of Breathing: No use of accessory muscles noted.
PAIN: No pain communicated or visualized by respiratory therapy at this time.

Interventions:
MEDICATION THERAPY: Small volume nebulizer treatment given via face mask for pediatric patient, with Albuterol 0.083% (2.5 mg/3 mL).
Treatment delivered via oxygen.

The patient had no adverse effects.

Post Therapy Assessment:
Heart Rate: 113 beats per minute
Respiratory Rate: 21 breaths per minute
Breath Sounds:
All Lung Fields: Diminished
Work of Breathing: No use of accessory muscles noted.
Cough/Suction: Patient had no cough at this time.

Education:
No education was provided at this time.

Electronically Signed By: Tashanna Greene, on 08/28/2017 at 22:06

Willis Knighton Respiratory

Account: K20034006872	Physician Name:	Admit Date: 8/28/2017 3:07:00 AM
First Name: [REDACTED]	MRN: 1116206	Discharge Date:
Last Name: [REDACTED]	Date of Birth: 10/01/2013	Charting Category: MEDTX
Charting Template: Treatment Note	Charting Date: 8/28/2017 8:25:00 PM	Charting ID: 1000997054

Heart Rate: 104 beats per minute
Respiratory Rate: 20 breaths per minute
All Lung Fields: Diminished
Work of Breathing: No use of accessory muscles noted.
PAIN: No pain communicated or visualized by respiratory therapy at this time.

Interventions:
MEDICATION THERAPY: Small volume nebulizer treatment given via face mask for pediatric patient, with Albuterol 0.083% (2.5 mg/3 mL)
Treatment delivered via oxygen.

The patient had no adverse effects.

Post Therapy Assessment:
Heart Rate: 104 beats per minute
Respiratory Rate: 20 breaths per minute
Breath Sounds:
All Lung Fields: Diminished
Work of Breathing: No use of accessory muscles noted.
Cough/Suction: Patient had no cough at this time.

Education:
No education was provided at this time.

Electronically Signed By: Tashanna Greene, on 08/28/2017 at 20:30

Willis Knighton Respiratory

Account: K20034006872

Physician Name:

Admit Date: 8/28/2017 3:07:00 AM

First Name: [REDACTED]

MRN: 1116206

Discharge Date:

Last Name: [REDACTED]

Date of Birth: 10/01/2013

Charting Category: MEDTX

Charting Template: Treatment Note

Charting Date: 8/28/2017 6:02:00 PM

Charting ID: 1000996832

Heart Rate: 138 beats per minute

Respiratory Rate: 18 breaths per minute

All Lung Fields: Clear

Work of Breathing: No use of accessory muscles noted.

PAIN: No pain communicated or visualized by respiratory therapy at this time.

Interventions:

MEDICATION THERAPY: Small volume nebulizer treatment given via face mask for pediatric patient, with Albuterol 0.083% (2.5 mg/3 mL)/Atrovent (Ipratropium Bromide) 0.02% Unit Dose (0.5 mg/2.5 mL) Treatment delivered via oxygen.

The patient had no adverse effects.

Post Therapy Assessment:

Heart Rate: 130 beats per minute

Respiratory Rate: 20 breaths per minute

Breath Sounds:

All Lung Fields: Clear

Work of Breathing: No use of accessory muscles noted.

Cough/Suction: Patient had a strong non-productive cough.

Education:

No education was provided at this time.

Electronically Signed By: Gentry Grisham, RRT on 08/28/2017 at 18:09

Willis Knighton Respiratory

Account: K20034006872	Physician Name:	Admit Date: 8/28/2017 3:07:00 AM
First Name: [REDACTED]	MRN: 1116206	Discharge Date:
Last Name: [REDACTED]	Date of Birth: 10/01/2013	Charting Category: MEDTX
Charting Template: Treatment Note	Charting Date: 8/28/2017 12:02:00 PM	Charting ID: 1000996403

Heart Rate: 154 beats per minute
Respiratory Rate: 20 breaths per minute
All Lung Fields: Clear
Work of Breathing: No use of accessory muscles noted.
PAIN: No pain communicated or visualized by respiratory therapy at this time.

Interventions:
MEDICATION THERAPY: Small volume nebulizer treatment given via face mask for pediatric patient, with Albuterol 0.083% (2.5 mg/3 mL)/Atrovent (Ipratropium Bromide) 0.02% Unit Dose (0.5 mg/2.5 mL). Treatment delivered via oxygen.

The patient had no adverse effects.

Post Therapy Assessment:
Heart Rate: 150 beats per minute
Respiratory Rate: 22 breaths per minute
Breath Sounds:
All Lung Fields: Clear
Work of Breathing: No use of accessory muscles noted.
Cough/Suction: Patient had a strong non-productive cough.

Education:
No education was provided at this time.

Electronically Signed By: Gentry Grisham, RRT on 08/28/2017 at 12:02

Willis Knighton Respiratory

Account: K20034006872	Physician Name:	Admit Date: 8/28/2017 3:07:00 AM
First Name: [REDACTED]	MRN: 1116206	Discharge Date:
Last Name: [REDACTED]	Date of Birth: 10/01/2013	Charting Category: MEDTX
Charting Template: Treatment Note	Charting Date: 8/28/2017 4:15:00 PM	Charting ID: 1000996723

Heart Rate: 124 beats per minute
Respiratory Rate: 22 breaths per minute
All Lung Fields: Clear
Work of Breathing: No use of accessory muscles noted.
PAIN: No pain communicated or visualized by respiratory therapy at this time.

Interventions:
MEDICATION THERAPY: Small volume nebulizer treatment given via face mask for pediatric patient, with Albuterol 0.083% (2.5 mg/3 mL)
Treatment delivered via oxygen.

The patient had no adverse effects.

Post Therapy Assessment:
Heart Rate: 124 beats per minute
Respiratory Rate: 18 breaths per minute
Breath Sounds:
All Lung Fields: Clear
Work of Breathing: No use of accessory muscles noted.
Cough/Suction: Patient had a strong non-productive cough.

Education:
No education was provided at this time.

Electronically Signed By: Gentry Grisham, RRT on 08/28/2017 at 16:20

Willis Knighton Respiratory

Account: K20034006872	Physician Name:	Admit Date: 8/28/2017 3:07:00 AM
First Name: [REDACTED]	MRN: 1116206	Discharge Date:
Last Name: [REDACTED]	Date of Birth: 10/01/2013	Charting Category: MEDTX
Charting Template: Treatment Note	Charting Date: 8/28/2017 1:52:00 PM	Charting ID: 1000996540

Heart Rate: 145 beats per minute
Respiratory Rate: 18 breaths per minute
All Lung Fields: Clear
Work of Breathing: No use of accessory muscles noted.
PAIN: No pain communicated or visualized by respiratory therapy at this time.

Interventions:
MEDICATION THERAPY: Small volume nebulizer treatment given via face mask for pediatric patient, with Albuterol 0.083% (2.5 mg/3 mL)
Treatment delivered via oxygen.

The patient had no adverse effects.

Post Therapy Assessment:
Heart Rate: 148 beats per minute
Respiratory Rate: 18 breaths per minute
Breath Sounds:
All Lung Fields: Clear
Work of Breathing: No use of accessory muscles noted.
Cough/Suction: Patient had a strong non-productive cough.

Education:
No education was provided at this time.

Electronically Signed By: Gentry Grisham, RRT on 08/28/2017 at 13:52

Willis Knighton Respiratory

Account: K20034006872	Physician Name:	Admit Date: 8/28/2017 3:07:00 AM
First Name: [REDACTED]	MRN: 1116206	Discharge Date:
Last Name: [REDACTED]	Date of Birth: 10/01/2013	Charting Category: MEDTX
Charting Template: Treatment Note	Charting Date: 8/28/2017 12:02:00 PM	Charting ID: 1000996403

Heart Rate: 154 beats per minute
Respiratory Rate: 20 breaths per minute
All Lung Fields: Clear
Work of Breathing: No use of accessory muscles noted.
PAIN: No pain communicated or visualized by respiratory therapy at this time.

Interventions:
MEDICATION THERAPY: Small volume nebulizer treatment given via face mask for pediatric patient, with Albuterol 0.083% (2.5 mg/3 mL)
Treatment delivered via oxygen.

The patient had no adverse effects.

Post Therapy Assessment:
Heart Rate: 150 beats per minute
Respiratory Rate: 22 breaths per minute
Breath Sounds:
All Lung Fields: Clear
Work of Breathing: No use of accessory muscles noted.
Cough/Suction: Patient had a strong non-productive cough.

Education:
No education was provided at this time.

Electronically Signed By: Gentry Grisham, RRT on 08/28/2017 at 12:02

Willis Knighton Respiratory

Account: K20034006872	Physician Name:	Admit Date: 8/28/2017 3:07:00 AM
First Name: [REDACTED]	MRN: 1116206	Discharge Date:
Last Name: [REDACTED]	Date of Birth: 10/01/2013	Charting Category: MEDTX
Charting Template: Treatment Note	Charting Date: 8/28/2017 9:20:00 AM	Charting ID: 1000996191

Heart Rate: 150 beats per minute
Respiratory Rate: 25 breaths per minute
All Lung Fields: Clear
Work of Breathing: No use of accessory muscles noted.
PAIN: No pain communicated or visualized by respiratory therapy at this time.

Interventions:
MEDICATION THERAPY: Small volume nebulizer treatment given via face mask for pediatric patient, with Albuterol 0.083% (2.5 mg/3 mL)
Treatment delivered via oxygen.

The patient had no adverse effects.

Post Therapy Assessment:
Heart Rate: 150 beats per minute
Respiratory Rate: 22 breaths per minute
Breath Sounds:
All Lung Fields: Clear
Work of Breathing: No use of accessory muscles noted.
Cough/Suction: Patient had a strong non-productive cough.

Education:
No education was provided at this time.

Electronically Signed By: Gentry Grisham, RRT on 08/28/2017 at 09:25

Willis Knighton Respiratory

Account: K20034006872	Physician Name:	Admit Date: 8/28/2017 3:07:00 AM
First Name: [REDACTED]	MRN: 1116206	Discharge Date:
Last Name: [REDACTED]	Date of Birth: 10/01/2013	Charting Category: MEDTX
Charting Template: Treatment Note	Charting Date: 8/28/2017 7:25:00 AM	Charting ID: 1000995949

Heart Rate: 136 beats per minute
Respiratory Rate: 30 breaths per minute
All Lung Fields: Expiratory wheezes
Work of Breathing: No use of accessory muscles noted.
PAIN: No pain communicated or visualized by respiratory therapy at this time.

Interventions:
MEDICATION THERAPY: Small volume nebulizer treatment given via face mask for pediatric patient, with Albuterol 0.083% (2.5 mg/3 mL)
Treatment delivered via oxygen.

The patient had no adverse effects.

Post Therapy Assessment:
Heart Rate: 130 beats per minute
Respiratory Rate: 30 breaths per minute
Breath Sounds:
All Lung Fields: Expiratory wheezes
Work of Breathing: No use of accessory muscles noted.
Cough/Suction: Patient had a strong non-productive cough.

Education:
Informal: Indications, possible side effects, expected outcomes of therapy and/or current status were explained.

Electronically Signed By: Gentry Grisham, RRT on 08/28/2017 at 07:30

Willis Knighton Respiratory

Account: K20034006872	Physician Name:	Admit Date: 8/28/2017 3:07:00 AM
First Name: [REDACTED]	MRN: 1116206	Discharge Date:
Last Name: [REDACTED]	Date of Birth: 10/01/2013	Charting Category: MEDGAS-SAT
Charting Template: Oxygen Therapy-Oximetry Note	Charting Date: 8/28/2017 7:25:00 AM	Charting ID: 1000995953

Pediatric Oxygen Protocol

Room Air SpO2 = 96 %. Oxygen therapy discontinued per protocol

Electronically Signed By: Gentry Grisham, RRT on 08/28/2017 at 07:32

Willis Knighton Respiratory

Account: K20034006872	Physician Name:	Admit Date: 8/28/2017 3:07:00 AM
First Name: [REDACTED]	MRN: 1116206	Discharge Date:
Last Name: [REDACTED]	Date of Birth: 10/01/2013	Charting Category: MEDTX
Charting Template: Treatment Note	Charting Date: 8/28/2017 5:05:00 AM	Charting ID: 1000995901

Heart Rate: 146 beats per minute
Respiratory Rate: 30 breaths per minute
All Lung Fields: Diminished
Work of Breathing: No use of accessory muscles noted.
PAIN: No pain communicated or visualized by respiratory therapy at this time.

Interventions:
MEDICATION THERAPY: Small volume nebulizer treatment started via mouth piece with Albuterol 0.083% (2.5 mg/3 mL)/Atrovent (Ipratropium Bromide) 0.02% Unit Dose (0.5 mg/2.5 mL) Treatment delivered via oxygen.

The patient had no adverse effects.

Post Therapy Assessment:
Heart Rate: 150 beats per minute
Respiratory Rate: 32 breaths per minute
Breath Sounds:
All Lung Fields: Diminished
Work of Breathing: No use of accessory muscles noted.
Cough/Suction: Patient had a strong non-productive cough.

Education:
No education was provided at this time.

Electronically Signed By: Chad Earley, RRT on 08/28/2017 at 05:26



AALIYAH L
 10/01/13 3Y 10M
 Tran, Sharon N M.D. S5517
 K20034006872 08/28/17
 Provider's Phone: (318)212-5781

Asthma Action Plan

Date/Time: _____



Red means Danger Zone! Get help from doctor.

Yellow means Caution zone! Add quick-relief medicine

Green means Go Zone! Use controller medicine

Parent Signature: _____

[] For Exercise: 20 minutes before take:

[] 2 Puffs [] Albuterol (ProAir, Proventil, Ventolin)
 [] 4 Puffs [] Levalbuterol (Xopenex)

Green = Go Zone

Use CONTROLLER Medications EVERY DAY and Avoid Asthma Triggers

You have ALL of these:

- Breathing is good
- No cough or wheeze
- Can work and play
- Sleep through the night

Controller Medication

How Much to Take

How Often

If peak flow meter used:

Peak flow greater than _____ above 80% of personal best

Personal best peak flow = _____

Rinse mouth or brush teeth after using Controller Medication

Yellow = Caution Zone

Getting Worse! Add QUICK RELIEVER Medication

You have ANY of these:

- Cough
- Mild Wheeze
- Tight Chest
- Waking at night - Can do some, but not due to asthma
- First sign of a cold
- Exposure to known trigger
- all usual activities

Continue DAILY Green Zone Controller Medications and ADD QUICK-RELIEVER:

☒ Albuterol (ProAir, Proventil, Ventolin) [] Levalbuterol (Xopenex)
☒ 2 puffs [] 4 puffs ☒ 1 nebulizer treatment

If better in 20 minutes, continue Quick-Reliever every 4-6 hours for 1-2 days

This is not where you should be every day.
 Take action to get your asthma under control.

☒ Call your provider at ☒ 24 hours [] 48 hours

If getting worse or not better by 1 hour, use Red Zone plan

If peak flow meter used: _____ to _____ (50% to 80% of personal best)

Red = Danger Zone

Take these Medicines and GET HELP NOW

Your asthma is bad

- Medicine is not helping within 10 to 20 minutes
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Trouble walking
- Trouble talking

Use QUICK RELIEVER

[] 2 puffs [] 4 puffs ☒ 6 puffs ☒ 1 nebulizer treatment

If not better in 20 minutes, repeat quick reliever while going to the hospital or provider's office - dial 911 if necessary

If peak flow meter used:

Peak flow below: _____
 (below 50% of personal best)

My asthma Triggers:

☒ Colds [] Smoke [] Weather [] Food [] Grass/Trees [] Cockroach's
☐ Exercise [] Dust [] Air pollution [] Animals [] Mold [] Fragrances
☐ Alcoholic Beverages ☒ Other: crying

Plan Of Care Report

Generated from 08/28/2017 00:00 to 09/01/2017 23:59

Pt Name: [REDACTED] L MRN: 1116206
 Pt ID: 0101757329 Acct No: K20034006872
 DOB: 10/01/2013 Age/Sex: 3Y/F
 Adm DTime: 08/28/2017 01:18 Attn Dr: Tran, Sharon MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Alerg: codeine, Fish Containing Products, Fish containing products

Plan of Care

Last Reviewed By: Amanda G Fortiz, RN

Last Reviewed Date: 08/30/2017 08:39

Standard Name	Date Assigned	Assigned By	Stop Date	Reason
POC Falls - Risk of	08/28/2017 04:31	Wallace, Meghan RN		
POC Breathing Pattern - Ineffect	08/28/2017 04:31	Wallace, Meghan RN		
Breathing Pattern Impairment	08/28/2017 04:31	Wallace, Meghan RN		

Problems associated to Selected Visit

Problem Name	Rank	Date Assigned	Date Closed	Assigned By	Closed By	Status
Problem Details	Value	Problem Details	Value	Problem Details	Value	
Breathing Pattern - Ineffective		08/28/2017 04:31		Meghan A Wallace, RN		Resolved
Status:						
Falls - Risk of		08/28/2017 04:31		Meghan A Wallace, RN		Resolved
Comment:		Status:				
Thermoregulation - Risk of, Impaired		08/28/2017 04:31		Meghan A Wallace, RN		Resolved
Comment:		Event:		Day Part:		
Severity:		Acute/Chronic:		Onset Date:		
Onset:		Status:				

Expected Outcomes

Expected Outcome Display Name	Status	Act. Outcome	Charted By
Comment	Target Completion Date	Status (Last)	Charted Date
Outcome Details	Value	Outcome Details	Value
Absence of falls	Active	Met	Gwendolyn K Kelley, RN
	08/31/2017 12:00		08/30/2017 03:10
Effective breathing pattern	Active	Progressing	Gwendolyn K Kelley, RN
	08/30/2017 12:00		08/30/2017 03:10

Pt Name: [REDACTED] L

MRN: 1116206

Plan Of Care Report

Rm/ Bed:

Page 1 of 1

ORE_0146_DSCH_NBR_v1.rpt v1.00

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 Printed On: 31-Aug-17 15:54

Assessment Report

Generated from 08/28/2017 00:00 to 09/01/2017 23:59

Pt Name: [REDACTED] L MRN: 1116206
 Pt ID: 0101757329 Acct No: K20034006872
 DOB: 10/01/2013 Age/Sex: 3Y/F
 Adm DTime: 08/28/2017 01:18 Attn Dr: Tran, Sharon MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Allrg: codeine, Fish Containing Products, Fish containing products

Admission Assessment

Assessment Sts Complete Collected DTime 08/28/2017 04:10
 Collected By Meghan A Wallace, RN

Admission Assessment

Stated reason for visit	wheezing, nasal congestion, cough, fever	Admit from	Home
Mode of arrival	Wheelchair	Accompanied by	Parent
Source of info	Parent	Would you like a family member / representative notified of your	No
Readmit within 30 days	Denies	Organ donor	No
Participates in Clinical Trial	No	No current treatments or therapies	Yes
Communication barriers	Cognitive, Emotional	Highest education level	Less than 5th grade
Language preference for medical communication	English	Communication barrier	None
Comment	Patient has autism	No spiritual/cultural issues that may affect care or education	Yes
Do you have an Advance Directive?	No	WKHS Patient Guide provided	Yes
Healthcare Power of Attorney	No	Healthcare Power of Attorney on file with WKHS	No
Oriented to	Yes		

Belongings / Equipment

Clothing	Yes	Clothing location	Family
Other home items	Yes	Other home items description	diaper bag
Other home items location	Family	No medical equipment or assistive devices	Yes

Birth History

Birth weight	708.738 g	Problems at birth	Mother had preeclampsia. Born at 27 weeks. NICU -100 days
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Past Med/Surg Hx

Neurological medical history	Other (specify)	Neurological comments	Autism
Respiratory medical history	Asthma	No additional history	Yes
No history of cancer	Yes		

Infectious Disease History

Pt Name: [REDACTED] L MRN: 1116206
 Rm/ Bed: Page 1 of 4

Assessment Report

ORE_0010_DSCH_NBR_V1.rpt v1.00

Printed By :Workflow

Printed On: 31-Aug-17 15:54

Assessment Report

Generated from 08/28/2017 00:00 to 09/01/2017 23:59

Pt Name: [REDACTED] L MRN: 1116206
 Pt ID: 0101757329 Acct No: K20034006872
 DOB: 10/01/2013 Age/Sex: 3Y/F
 Adm DTime: 08/28/2017 01:18 Atn Dr: Tran, Sharon MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Alrg: codeine, Fish Containing Products, Fish containing products

Admission Assessment

Assessment Sts Complete Collected DTime 08/28/2017 04:10
 Collected By Meghan A Wallace, RN

Infectious Disease History

No history of infectious disease	Yes	Have you/close contact travel outside continental US last 30days	No
Have you come in contact with any person with confirmed Ebola	No	Have you or close contact come in contact with anyone with ZIKA	No

Health Screening

Hazardous material exposure	Unknown	No change in appetite, unintentional weight loss, vomiting or	Yes
Body Mass Index	19.00	Weight	36/15.897 lbs,oz
Height	3/1 ft,in		

Developmental Assessment

3 Years Able to throw ball overhand

Immunization Screening

Contraindications	Patient under 18 years of age	Contraindications	Patient under 65 years of age
Childhood Immunizations up to date	Yes	Immunization comments	UTD
Hepatitis A vaccine yes/no	Yes	Hepatitis B vaccine yes/no	Yes
Tetanus vaccine in last 10 years	Yes		

Family Health History

Father	Not known	Mother	Hypertension, Obesity
Brother	Not known		

Psychosocial History

Marital Status	Single	Smoking status	Never smoker
Have you had thoughts of harming yourself in the past week?	Unable to assess	Does your home environment cause you fear, pain, or injury?	Unable to assess
Have you recently felt abused, taken advantage of, or neglected	Unable to assess	Spiritual resources needed	No

ADL Assessment

Activity Partial assist

Vital Signs

Pt Name: [REDACTED] L

MRN: 1116206

Assessment Report

Rm/ Bed:

Page 2 of 4

ORE_0010_DSCH_NBR_V1.rpt v1.00

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Assessment Report

Generated from 08/28/2017 00:00 to 09/01/2017 23:59

Pt Name: [REDACTED] L MRN: 1116206
 Pt ID: 0101757329 Acct No: K20034006872
 DOB: 10/01/2013 Age/Sex: 3Y/F
 Adm DTime: 08/28/2017 01:18 Atn Dr: Tran, Sharon MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Alrg: codeine, Fish Containing Products, Fish containing products

Admission Assessment

Assessment Sts Complete Collected DTime 08/28/2017 04:10
 Collected By Meghan A Wallace, RN

Vital Signs

Temperature	98.3 F	Temperature Site	Temporal
Pulse	156	Pulse site	VS machine
Respirations	28	WFE Respiratory rate	28
O2 Saturation (%)	97	Blood pressure 1	110/79 *H*
Site Blood pressure 1	Leg, right	Position BP 1	Sitting
Method Blood pressure 1	Cuff, automatic	Height	3/1 ft,in
How Obtained	Stated	Weight	36/15.897 lbs,oz
How Obtained	Measured	Body Mass Index	19.00
Ideal Body Weight, female	-14.86	Ideal Body Weight, male	-4.86

Pain / Sedation Assessment

Face	No particular expression or smile	Legs	Normal position or relaxed
Activity	Lying quietly, normal position, moves easily	Cry	No cry

HEENT Assessment

Head	WDL	Eyes	WDL
Ears	WDL	Nose	WDL
Mouth	WDL	Throat	WDL

Respiratory Assessment

Oxygen	WDL	O2 Saturation (%)	97
Respiratory	WDL except	Respiratory pattern	Tachypnea
Retracting / Bulging	Mild retracting	Cough	Non - productive
Breath sounds within defined limits	WDL except	LUL	Wheezes, expiratory, Wheezes, inspiratory
RUL	Wheezes, expiratory, Wheezes, inspiratory	RML	Wheezes, expiratory, Wheezes, inspiratory

Cardiovascular Assessment

Cardiovascular	WDL	Peripheral circulation	WDL
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Gastrointestinal Assessment

Gastrointestinal	WDL
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Genitourinary Assessment

Genitourinary	WDL	Urinary catheter present on admission	Not applicable
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Pt Name: [REDACTED] L

MRN: 1116206

Assessment Report

Rm/ Bed:

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ORE_0010_DSCH_NBR_V1.rpt v1.00

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Assessment Report

Generated from 08/28/2017 00:00 to 09/01/2017 23:59

Pt Name: [REDACTED] L MRN: 1116206
 Pt ID: 0101757329 Acct No: K20034006872
 DOB: 10/01/2013 Age/Sex: 3Y/F
 Adm DTime: 08/28/2017 01:18 Attn Dr: Tran, Sharon MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Allrg: codeine, Fish Containing Products, Fish containing products

Admission Assessment

Assessment Sts Complete Collected DTime 08/28/2017 04:10
 Collected By Meghan A Wallace, RN

Genitourinary Assessment

Indwelling Urinary No External genitalia Deferred
 Catheter present on admission

Musculoskeletal Assessment

Musculoskeletal WDL Bones and Joints WDL

Neurological Assessment

Neurological WDL Oriented to person, place and time Yes
 Motor function WDL

Integumentary Assessment

Integumentary WDL

Fall Risk Assessment

Age Less than 3 years old Gender Female
 Diagnosis Alterations in oxygenation (respiratory diagnosis, dehydration, anemia, anorexia, syncope / dizziness, etc.) Cognitive Impairment Not aware of limitations
 Environmental Factors Placed in bed Response to Surgery/Sedation/Anesthesia More than 48 hours / None
 Medication Usage Other medications / None Humpty Dumpty score 15
 Fall risk level High risk Interventions Fall-precaution Identifier implementation (yellow falls wrist band applied, fall risk ID magnet at door)

Education - Multidisciplinary

Nursing education topic Safety Person educated Parent
 Barriers to learning None Readiness to Learn Receptive
 Teaching method Discussion Understanding Good
 Evaluation Method Verbal Follow-up No Follow-up Needed

Discharge Planning

Comment per md upon discharge

Clinical Note:

Pt Name: [REDACTED] L
 Rm/ Bed:

MRN: 1116206
 Page 4 of 4

Assessment Report

Generated from 08/28/2017 00:00 to 09/01/2017 23:59

Pt Name: [REDACTED] L MRN: 1116206
 Pt ID: 0101757329 Acct No: K20034006872
 DOB: 10/01/2013 Age/Sex: 3Y/F
 Adm DTime: 08/28/2017 01:18 Attn Dr: Tran, Sharon MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Allrg: codeine, Fish Containing Products, Fish containing products

Discharge Assessment

Assessment Sts Complete Collected DTime 08/30/2017 14:02
 Collected By Amanda G Fortiz, RN

Discharge Assessment

Care Management discharge planning completed	Yes	Wound Ostomy discharge planning completed	Yes
Temperature	98.5 F	Pulse	105
Respirations	26	O2 Saturation (%)	100
Date of last bowel movement	08/30/2017	Contraindications	Patient under 65 years of age
Contraindications	Patient under 18 years of age, Vaccine not required (April - August)	Discharge instructions	Reviewed discharge instructions with patient / significant other, Patient / Significant other verbalized understanding of discharge instructions, Patient / Significant other received written instructions
Physician discharge order complete	Yes	Discharge medication reconciliation complete	Yes

Discharge Follow-up and Equipment

With Referral 1	PCP at UH	Follow-up In	3-4 days
With Referral 2	Dr. Jones, Peds Pulmonology	Follow-up In	as scheduled
Care Management discharge planning completed	Yes		

Integumentary Assessment

Integumentary	WDL	
---------------	-----	--

WOC Discharge Planning

Wound Ostomy discharge planning completed	Yes
---	-----

Education - Multidisciplinary

Nursing education topic	Asthma	Person educated	Parent
Barriers to learning	Cognitive	Readiness to Learn	Receptive
Understanding	Good	Evaluation Method	Verbal
Follow-up	Content, No Follow-up Needed		

Physician D/C Instructions

Diet	Pediatric	Activity	No Activity Restrictions
Notify Physician For	Fever or chills, Shortness of		breath, If symptoms worsen

Pt Name: [REDACTED] L

MRN: 1116206

Assessment Report

Rm/ Bed:

Page 1 of 2

ORE_0010_DSCH_NBR_V1.rpt v1.00

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Assessment Report

Generated from 08/28/2017 00:00 to 09/01/2017 23:59

Pt Name: [REDACTED] L MRN: 1116206
Pt ID: 0101757329 Acct No: K20034006872
DOB: 10/01/2013 Age/Sex: 3Y/F
Adm DTime: 08/28/2017 01:18 Atn Dr: Tran, Sharon MD
Nurs Sta: S 5 East 1 Rm & Bed:
Dx:
Alrg: codeine, Fish Containing Products, Fish containing products

Discharge Assessment

Assessment Sts Complete Collected DTime 08/30/2017 14:02
Collected By Amanda G Fortiz, RN

Physician D/C Instructions

contact your health care
provider or call 911

Clinical Note:

Discharge Follow-up and Equipment

Assessment Sts Complete Collected DTime 08/30/2017 14:13
Collected By Amanda G Fortiz, RN

Discharge Follow-up and Equipment

With Referral 1	PCP at UH	Follow-up In	3-4 days
With Referral 2	Dr. Jones, Peds Pulmonology	Follow-up In	as scheduled
Care Management discharge planning completed	Yes		

Clinical Note:

Pt Name: [REDACTED] L

MRN: 1116206

Assessment Report

Rm/ Bed:

Page 2 of 2

ORE_0010_DSCH_NBR_V1.rpt v1.00

Printed By :Workflow

Assessment Report

Generated from 08/28/2017 00:00 to 09/01/2017 23:59

Pt Name: [REDACTED] L MRN: 1116206
Pt ID: 0101757329 Acct No: K20034006872
DOB: 10/01/2013 Age/Sex: 3Y/F
Adm DTime: 08/28/2017 01:18 Atn Dr: Tran, Sharon MD
Nurs Sta: S 5 East 1 Rm & Bed:
Dx:
Alrg: codeine, Fish Containing Products, Fish containing products

Patient Factors

Assessment Sts Complete Collected DTime 08/29/2017 19:30
Collected By Gwendolyn K Kelley, RN

Patient Factors

Height	3/1 ft,in	How Obtained	Stated
Weight	36/15.897 lbs,oz	How Obtained	Measured
Body Mass Index	19.00	Oriented to person, place and time	No
Isolation precautions	None	Fall precautions	Yes
Requires assistance with transfers	No	Transportation method	Stretcher
IV	No	Support person	Mother
O2 in use	No		

Clinical Note:

Patient Factors

Assessment Sts Complete Collected DTime 08/28/2017 19:30
Collected By Gwendolyn K Kelley, RN

Patient Factors

Height	3/1 ft,in	How Obtained	Stated
Weight	36/15.897 lbs,oz	How Obtained	Measured
Body Mass Index	19.00	Oriented to person, place and time	Yes
Isolation precautions	None	Fall precautions	Yes
Requires assistance with transfers	No	Transportation method	Stretcher
IV	Yes	Support person	Mother
O2 in use	No		

Clinical Note:

Patient Factors

Assessment Sts Complete Collected DTime 08/28/2017 04:08
Collected By Meghan A Wallace, RN

Patient Factors

Height	3/1 ft,in	How Obtained	Stated
Weight	16.78 kg	How Obtained	Measured
Body Mass Index	19.00	Oriented to person, place and time	Yes
Isolation precautions	None	Fall precautions	No
Requires assistance with transfers	No	Transportation method	Stretcher

Pt Name: [REDACTED] L

MRN: 1116206

Assessment Report

Rm/ Bed:

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ORE_0010_DSCH_NBR_V1.rpt v1.00

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Assessment Report

Generated from 08/28/2017 00:00 to 09/01/2017 23:59

Pt Name: [REDACTED] L MRN: 1116206
 Pt ID: 0101757329 Acct No: K20034006872
 DOB: 10/01/2013 Age/Sex: 3Y/F
 Adm DTime: 08/28/2017 01:18 Atn Dr: Tran, Sharon MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Alrg: codeine, Fish Containing Products, Fish containing products

Patient Factors

Assessment Sts Complete Collected DTime 08/28/2017 04:08
 Collected By Meghan A Wallace, RN

Patient Factors

IV Yes Support person Mother
 O2 in use No

Clinical Note:

Vital Signs

Assessment Sts Complete Collected DTime 08/30/2017 11:00
 Collected By Amanda G Fortiz, RN

Vital Signs

Temperature	98.5 F	Temperature Site	Temporal
Pulse	71	Pulse site	VS machine
Respirations	24	WFE Respiratory rate	24
O2 Saturation (%)	100	Height	3/1 ft,in
How Obtained	Stated	Weight	36/15.897 lbs,oz
How Obtained	Measured	Body Mass Index	19.00
Ideal Body Weight, female	-14.86	Ideal Body Weight, male	-4.86

Clinical Note:

Vital Signs

Assessment Sts Complete Collected DTime 08/30/2017 04:00
 Collected By Gwendolyn K Kelley, RN

Vital Signs

Temperature	97.8 F	Temperature Site	Temporal
Pulse	88	Pulse site	VS machine
Respirations	24	WFE Respiratory rate	24
O2 Saturation (%)	94	Height	3/1 ft,in
How Obtained	Stated	Weight	36/15.897 lbs,oz
How Obtained	Measured	Body Mass Index	19.00
Ideal Body Weight, female	-14.86	Ideal Body Weight, male	-4.86

Clinical Note:

Vital Signs

Assessment Sts Complete Collected DTime 08/30/2017 00:00
 Collected By Gwendolyn K Kelley, RN

Vital Signs

Temperature	97.3 F	Temperature Site	Temporal
Pulse	95	Pulse site	VS machine

Pt Name: [REDACTED] L
 Rm/ Bed:

MRN: 1116206
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Assessment Report

ORE_0010_DSCH_NBR_V1.rpt v1.00

Printed By :Workflow

Printed On: 31-Aug-17 15:54

Assessment Report

Generated from 08/28/2017 00:00 to 09/01/2017 23:59

Pt Name: [REDACTED] L MRN: 1116206
 Pt ID: 0101757329 Acct No: K20034006872
 DOB: 10/01/2013 Age/Sex: 3Y/F
 Adm DTime: 08/28/2017 01:18 Attn Dr: Tran, Sharon MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Allrg: codeine, Fish Containing Products, Fish containing products

Vital Signs

Assessment Sts Complete Collected DTime 08/30/2017 00:00
 Collected By Gwendolyn K Kelley, RN

Vital Signs

Respirations	24	WFE Respiratory rate	24
O2 Saturation (%)	96	Height	3/1 ft,in
How Obtained	Stated	Weight	36/15.897 lbs,oz
How Obtained	Measured	Body Mass Index	19.00
Ideal Body Weight, female	-14.86	Ideal Body Weight, male	-4.86

Clinical Note:

Vital Signs

Assessment Sts Complete Collected DTime 08/29/2017 16:00
 Collected By Catrina J Lewis, RN

Vital Signs

Temperature	98.5 F	Temperature Site	Temporal
Pulse	126	Pulse site	VS machine
Respirations	30	WFE Respiratory rate	30
O2 Saturation (%)	98	Height	3/1 ft,in
How Obtained	Stated	Weight	36/15.897 lbs,oz
How Obtained	Measured	Body Mass Index	19.00
Ideal Body Weight, female	-14.86	Ideal Body Weight, male	-4.86

Clinical Note:

Vital Signs

Assessment Sts Complete Collected DTime 08/29/2017 12:00
 Collected By Catrina J Lewis, RN

Vital Signs

Temperature	99.1 F	Temperature Site	Temporal
Pulse	100	Pulse site	VS machine
Respirations	40	WFE Respiratory rate	40
O2 Saturation (%)	98	Height	3/1 ft,in
How Obtained	Stated	Weight	36/15.897 lbs,oz
How Obtained	Measured	Body Mass Index	19.00
Ideal Body Weight, female	-14.86	Ideal Body Weight, male	-4.86

Clinical Note:

Vital Signs

Assessment Sts Complete Collected DTime 08/29/2017 08:23
 Collected By Catrina J Lewis, RN

Pt Name: [REDACTED] L

MRN: 1116206

Assessment Report

Rm/ Bed:

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ORE_0010_DSCH_NBR_V1.rpt v1.00

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 DOB: 10/01/2013 Age/Sex: 3Y/F
 Adm DTime: 08/28/2017 01:18 Atn Dr: Tran, Sharon MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Alrg: codeine, Fish Containing Products, Fish containing products

Vital Signs

Assessment Sts Complete Collected DTime 08/29/2017 08:23
 Collected By Catrina J Lewis, RN

Vital Signs

Temperature	98.1 F	Temperature Site	Temporal
Pulse	130	Pulse site	VS machine
Respirations	32	WFE Respiratory rate	32
O2 Saturation (%)	99	Height	3/1 ft,in
How Obtained	Stated	Weight	36/15.897 lbs,oz
How Obtained	Measured	Body Mass Index	19.00
Ideal Body Weight, female	-14.86	Ideal Body Weight, male	-4.86

Clinical Note:

Vital Signs

Assessment Sts Complete Collected DTime 08/29/2017 04:00
 Collected By Gwendolyn K Kelley, RN

Vital Signs

Temperature	97.8 F	Temperature Site	Temporal
Pulse	104	Pulse site	VS machine
Respirations	32	WFE Respiratory rate	32
O2 Saturation (%)	100	Height	3/1 ft,in
How Obtained	Stated	Weight	36/15.897 lbs,oz
How Obtained	Measured	Body Mass Index	19.00
Ideal Body Weight, female	-14.86	Ideal Body Weight, male	-4.86

Clinical Note:

Vital Signs

Assessment Sts Complete Collected DTime 08/29/2017 00:00
 Collected By Gwendolyn K Kelley, RN

Vital Signs

Temperature	97.9 F	Temperature Site	Temporal
Pulse	117	Pulse site	VS machine
Respirations	28	WFE Respiratory rate	28
O2 Saturation (%)	96	Height	3/1 ft,in
How Obtained	Stated	Weight	36/15.897 lbs,oz
How Obtained	Measured	Body Mass Index	19.00
Ideal Body Weight, female	-14.86	Ideal Body Weight, male	-4.86

Clinical Note:

Vital Signs

Pt Name: [REDACTED] L
 Rm/ Bed:

MRN: 1116206
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Assessment Report

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 Adm DTime: 08/28/2017 01:18 Attn Dr: Tran, Sharon MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Alrg: codeine, Fish Containing Products, Fish containing products

Vital Signs

Assessment Sts Complete Collected DTime 08/28/2017 16:00
 Collected By Catrina J Lewis, RN

Vital Signs

Temperature	99.9 F	Temperature Site	Axillary
Pulse	131	Pulse site	VS machine
Respirations	36	WFE Respiratory rate	36
O2 Saturation (%)	100	Height	3/1 ft,in
How Obtained	Stated	Weight	36/15.897 lbs,oz
How Obtained	Measured	Body Mass Index	19.00
Ideal Body Weight, female	-14.86	Ideal Body Weight, male	-4.86

Clinical Note:

Vital Signs

Assessment Sts Complete Collected DTime 08/28/2017 12:00
 Collected By Catrina J Lewis, RN

Vital Signs

Temperature	99.9 F	Temperature Site	Axillary
Pulse	160	Pulse site	VS machine
Respirations	52	WFE Respiratory rate	52
O2 Saturation (%)	94	Height	3/1 ft,in
How Obtained	Stated	Weight	36/15.897 lbs,oz
How Obtained	Measured	Body Mass Index	19.00
Ideal Body Weight, female	-14.86	Ideal Body Weight, male	-4.86

Clinical Note:

Vital Signs

Assessment Sts Complete Collected DTime 08/28/2017 08:00
 Collected By Catrina J Lewis, RN

Vital Signs

Temperature	98.8 F	Temperature Site	Temporal
Pulse	150	Pulse site	VS machine
Respirations	58	WFE Respiratory rate	58
O2 Saturation (%)	95	Height	3/1 ft,in
How Obtained	Stated	Weight	36/15.897 lbs,oz
How Obtained	Measured	Body Mass Index	19.00
Ideal Body Weight, female	-14.86	Ideal Body Weight, male	-4.86

Clinical Note:

WOC Discharge Planning

Pt Name: [REDACTED] L
 Rm/ Bed:

MRN: 1116206
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Assessment Report

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 DOB: 10/01/2013 Age/Sex: 3Y/F
 Adm DTime: 08/28/2017 01:18 Atn Dr: Tran, Sharon MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 AArg: codeine, Fish Containing Products, Fish containing products

WOC Discharge Planning

Assessment Sts Complete Collected DTime 08/30/2017 14:12
 Collected By Amanda G Fortiz, RN

WOC Discharge Planning

Wound Ostomy discharge planning completed Yes

Clinical Note:

Pt Name: [REDACTED] L
 Rm/ Bed:

MRN: 1116206
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Assessment Report

Generated from 08/28/2017 00:00 to 09/01/2017 23:59

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 Pt ID: 0101757329 Acct No: K20034006872
 DOB: 10/01/2013 Age/Sex: 3Y/F
 Adm DTime: 08/28/2017 01:18 Attn Dr: Tran, Sharon MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Alrg: codeine, Fish Containing Products, Fish containing products

Intake and Output

	08/30/17 04:23	08/29/17 18:00	08/29/17 05:03	08/28/17 18:00	08/28/17 06:16
Collected By	Gwendolyn K Kelley, RN	Catrina J Lewis, RN	Gwendolyn K Kelley, RN	Catrina J Lewis, RN	Meghan A Wallace, RN
Clinical Note					
Status	Complete	Complete	Complete	Complete	Complete
Oral	120 ml	950 ml	120 ml	120 ml	
IV fluid #1		261.52 ml	420 ml	652.40 ml	100 ml

Discharge Follow-up and Equipment

Assessment Sts Complete Collected DTime 08/30/2017 14:13
 Collected By Amanda G Fortiz, RN

Discharge Follow-up and Equipment

With Referral 1 PCP at UH Follow-up In 3-4 days
 With Referral 2 Dr. Jones, Peds Pulmonology Follow-up In as scheduled
 Care Management Yes
 discharge planning completed

Clinical Note:

Peripheral IV Assessment

Assessment Sts Complete Collected DTime 08/29/2017 14:42
 Collected By Catrina J Lewis, RN

Peripheral IV Assessment

Date / Time Discontinued, 08/29/2017 13:45 Catheter Intact IV 1 Yes
 site 1
 Description, site 1 no redness or swelling

Clinical Note:

Peripheral IV Assessment

Assessment Sts Complete Collected DTime 08/29/2017 12:00
 Collected By Catrina J Lewis, RN

Peripheral IV Assessment

Site IV 1 Antecubital, right Size IV 1 22G
 IV site condition IV 1 Patent, no redness, Dressing condition IV 1 Clean, dry, intact
 tenderness, leakage or edema

Clinical Note:

Peripheral IV Assessment

Pt Name: [REDACTED] L

MRN: 1116206

Assessment Report

Rm/ Bed:

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ORE_0010_DSCH_NBR_V1.rpt v1.00

Assessment Report

Generated from 08/28/2017 00:00 to 09/01/2017 23:59

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 Pt ID: 0101757329 Acct No: K20034006872
 DOB: 10/01/2013 Age/Sex: 3Y/F
 Adm DTime: 08/28/2017 01:18 Attn Dr: Tran, Sharon MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Alrg: codeine, Fish Containing Products, Fish containing products

Peripheral IV Assessment

Assessment Sts Complete Collected DTime 08/29/2017 10:00
 Collected By Catrina J Lewis, RN

Peripheral IV Assessment

Site IV 1	Antecubital, right	Size IV 1	22G
IV site condition IV 1	Patent, no redness, tenderness, leakage or edema	Dressing condition IV 1	Clean, dry, intact

Clinical Note:

Peripheral IV Assessment

Assessment Sts Complete Collected DTime 08/29/2017 08:00
 Collected By Catrina J Lewis, RN

Peripheral IV Assessment

Site IV 1	Antecubital, right	Size IV 1	22G
IV site condition IV 1	Patent, no redness, tenderness, leakage or edema	Dressing condition IV 1	Clean, dry, intact

Clinical Note:

Peripheral IV Assessment

Assessment Sts Complete Collected DTime 08/29/2017 06:13
 Collected By Gwendolyn K Kelley, RN

Peripheral IV Assessment

Site IV 1	Antecubital, right	Size IV 1	22G
IV site condition IV 1	Patent, no redness, tenderness, leakage or edema	Dressing condition IV 1	Clean, dry, intact

Clinical Note:

Peripheral IV Assessment

Assessment Sts Complete Collected DTime 08/29/2017 04:00
 Collected By Gwendolyn K Kelley, RN

Peripheral IV Assessment

Site IV 1	Antecubital, right	Size IV 1	22G
IV site condition IV 1	Patent, no redness, tenderness, leakage or edema	Dressing condition IV 1	Clean, dry, intact

Clinical Note:

Peripheral IV Assessment

Assessment Sts Complete Collected DTime 08/29/2017 01:30
 Collected By Gwendolyn K Kelley, RN

Peripheral IV Assessment

Site IV 1	Antecubital, right	Size IV 1	22G
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Pt Name: [REDACTED] L

MRN: 1116206

Assessment Report

Rm/ Bed:

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ORE_0010_DSCH_NBR_V1.rpt v1.00

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Printed On: 31-Aug-17 15:54

Assessment Report

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Pt Name: [REDACTED] L MRN: 1116206
Pt ID: 0101757329 Acct No: K20034006872
DOB: 10/01/2013 Age/Sex: 3Y/F
Adm DTime: 08/28/2017 01:18 Atn Dr: Tran, Sharon MD
Nurs Sta: S 5 East 1 Rm & Bed:
Dx:
Alrg: codeine, Fish Containing Products, Fish containing products

Peripheral IV Assessment

Assessment Sts Complete Collected DTime 08/29/2017 01:30
Collected By Gwendolyn K Kelley, RN

Peripheral IV Assessment

IV site condition IV 1 Patent, no redness, tenderness, leakage or edema Dressing condition IV 1 Clean, dry, intact

Clinical Note:

Peripheral IV Assessment

Assessment Sts Complete Collected DTime 08/29/2017 00:00
Collected By Gwendolyn K Kelley, RN

Peripheral IV Assessment

Site IV 1 Antecubital, right Size IV 1 22G
IV site condition IV 1 Patent, no redness, tenderness, leakage or edema Dressing condition IV 1 Clean, dry, intact

Clinical Note:

Peripheral IV Assessment

Assessment Sts Complete Collected DTime 08/28/2017 21:30
Collected By Gwendolyn K Kelley, RN

Peripheral IV Assessment

Site IV 1 Antecubital, right Size IV 1 22G
IV site condition IV 1 Patent, no redness, tenderness, leakage or edema Dressing condition IV 1 Clean, dry, intact

Clinical Note:

Peripheral IV Assessment

Assessment Sts Complete Collected DTime 08/28/2017 19:30
Collected By Gwendolyn K Kelley, RN

Peripheral IV Assessment

Site IV 1 Antecubital, right Size IV 1 22G
IV site condition IV 1 Patent, no redness, tenderness, leakage or edema Dressing condition IV 1 Clean, dry, intact

Clinical Note:

Peripheral IV Assessment

Assessment Sts Complete Collected DTime 08/28/2017 18:00
Collected By Catrina J Lewis, RN

Peripheral IV Assessment

Site IV 1 Antecubital, right Size IV 1 22G
IV site condition IV 1 Patent, no redness, tenderness, leakage or edema Dressing condition IV 1 Clean, dry, intact

Pt Name: [REDACTED] L

MRN: 1116206

Assessment Report

Rm/ Bed:

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DOB: 10/01/2013 Age/Sex: 3Y/F
Adm DTime: 08/28/2017 01:18 Atn Dr: Tran, Sharon MD
Nurs Sta: S 5-East 1 Rm & Bed:
Dx:
Alrg: codeine, Fish Containing Products, Fish containing products

Peripheral IV Assessment

Assessment Sts Complete Collected DTime 08/28/2017 18:00
Collected By Catrina J Lewis, RN

Clinical Note:

Peripheral IV Assessment

Assessment Sts Complete Collected DTime 08/28/2017 12:00
Collected By Catrina J Lewis, RN

Peripheral IV Assessment

Site IV 1	Antecubital, right	Size IV 1	22G
IV site condition IV 1	Patent, no redness, tenderness, leakage or edema	Dressing condition IV 1	Clean, dry, intact

Clinical Note:

Peripheral IV Assessment

Assessment Sts Complete Collected DTime 08/28/2017 10:00
Collected By Catrina J Lewis, RN

Peripheral IV Assessment

Site IV 1	Antecubital, right	Size IV 1	22G
IV site condition IV 1	Patent, no redness, tenderness, leakage or edema	Dressing condition IV 1	Clean, dry, intact

Clinical Note:

Peripheral IV Assessment

Assessment Sts Complete Collected DTime 08/28/2017 08:00
Collected By Catrina J Lewis, RN

Peripheral IV Assessment

Site IV 1	Antecubital, right	Size IV 1	22G
IV site condition IV 1	Patent, no redness, tenderness, leakage or edema	Dressing condition IV 1	Clean, dry, intact

Clinical Note:

Peripheral IV Assessment

Assessment Sts Complete Collected DTime 08/28/2017 05:17
Collected By Meghan A Wallace, RN

Peripheral IV Assessment

Site IV 1	Antecubital, right	Size IV 1	22G
IV site condition IV 1	Patent, no redness, tenderness, leakage or edema	Dressing condition IV 1	Clean, dry, intact

Clinical Note:

Peripheral IV Assessment

Pt Name: [REDACTED] L MRN: 1116206
Rm/ Bed: Page 4 of 16

Assessment Report

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 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Allrg: codeine, Fish Containing Products, Fish containing products

Peripheral IV Assessment

Assessment Sts Complete Collected DTime 08/28/2017 04:31
 Collected By Meghan A Wallace, RN

Peripheral IV Assessment

Site IV 1	Antecubital, right	Size IV 1	22G
IV site condition IV 1	Patent, no redness, tenderness, leakage or edema	Dressing condition IV 1	Clean, dry, intact
Comments, site 1	d5 1/2ns with 20 kcl @55		

Clinical Note:

Peripheral IV Assessment

Assessment Sts Complete Collected DTime 08/28/2017 04:09
 Collected By Meghan A Wallace, RN

Peripheral IV Assessment

Site IV 1	Antecubital, right	Size IV 1	22G
Dressing type IV 1	Sterile transparent semipermeable	Securement device, site 1	Tape
IV site condition IV 1	Patent, no redness, tenderness, leakage or edema	Dressing condition IV 1	Clean, dry, intact
Flushed per procedure IV 1	Yes		

Clinical Note:

Reassessment

Assessment Sts Complete Collected DTime 08/30/2017 07:10
 Collected By Amanda G Fortiz, RN

Reassessment

Temperature	98. F	Temperature Site	Temporal
Pulse	103	Pulse site	VS machine
Respirations	28	O2 Saturation (%)	95
Height	3/1 ft,in	How Obtained	Stated
Weight	36/15.897 lbs,oz	How Obtained	Measured
Body Mass Index	19.00	Ideal Body Weight, female	-14.86
Ideal Body Weight, male	-31.83		

Patient Location

Primary location In their primary assigned location

Pain / Sedation Assessment

No complaints of pain at this time	Yes	Total score	0
Face	No particular expression or smile	Legs	Normal position or relaxed

Pt Name: [REDACTED] L

MRN: 1116206

Assessment Report

Rm/ Bed:

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 Adm DTime: 08/28/2017 01:18 Atn Dr: Tran, Sharon MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Alrg: codeine, Fish Containing Products, Fish containing products

Reassessment

Assessment Sts	Complete	Collected DTime	08/30/2017 07:10
Collected By	Amanda G Fortiz, RN		
<u>Pain / Sedation Assessment</u>			
Activity	Lying quietly, normal position, moves easily	Cry	No cry
Consolability	Content, relaxed		
<u>HEENT Assessment</u>			
Head	WDL	Eyes	WDL
Ears	WDL	Nose	WDL
Mouth	WDL	Throat	WDL
<u>Respiratory Assessment</u>			
Oxygen	WDL	O2 Saturation (%)	95
Respiratory	WDL	Breath sounds within defined limits	WDL except
LUL	Coarse rales	LLL	Coarse rales
RUL	Coarse rales	RML	Coarse rales
RLL	Coarse rales		
<u>Cardiovascular Assessment</u>			
Cardiovascular	WDL	Peripheral circulation	WDL
<u>Gastrointestinal Assessment</u>			
Gastrointestinal	WDL	Equipment	Pads / briefs
<u>Genitourinary Assessment</u>			
Genitourinary	WDL	Equipment	Pads / briefs
Urinary catheter present on admission	Not applicable	Indwelling Urinary Catheter present on admission	No
External genitalia	WDL		
<u>Musculoskeletal Assessment</u>			
Musculoskeletal	WDL	Bones and Joints	WDL
<u>Neurological Assessment</u>			
Eye opening	Spontaneous	Motor response	Moves spontaneously or purposefully
Verbal response	Smiles, oriented to sounds, follows objects, interacts	GCS Total Score	15
Neurological	WDL except	Oriented to	Person
Oriented to person, place and time	No	Behavior	Quiets easily

Pt Name: [REDACTED] L

MRN: 1116206

Assessment Report

Rm/ Bed:

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 Dx:
 Alrg: codeine, Fish Containing Products, Fish containing products

Reassessment

Assessment Sts Complete Collected DTime 08/30/2017 07:10
 Collected By Amanda G Fortiz, RN

Neurological Assessment

Motor function WDL

Integumentary Assessment

Integumentary WDL

Braden Skin Risk Assessment

Mobility: Ability to change and control body position	No Limitations	Activity: Degree of physical activity	Walks Frequently
Sensory Perception:	No Impairment	Moisture	Occasionally Moist
Friction and shear	No Apparent Problem	Nutrition: Usual food intake pattern	Excellent
Tissue perfusion and oxygenation	Excellent	Modified Braden Score	27

Fall Risk Assessment

Age	Less than 3 years old	Gender	Female
Diagnosis	Alterations in oxygenation (respiratory diagnosis, dehydration, anemia, anorexia, syncope / dizziness, etc.)	Cognitive Impairment	Forgets limitations
Environmental Factors	Placed in bed	Response to Surgery/Sedation/Anesthesia	More than 48 hours / None
Medication Usage	Other medications / None	Humpty Dumpty score	14
Fall risk level	High risk	Interventions	Fall-precaution identifier implementation (yellow falls wrist band applied, fall risk ID magnet at door)

Education - Multidisciplinary

Nursing education topic	Asthma	Readiness to learn	Apprehensive / Reluctant
Person educated	Parent	Barriers to learning	None
Readiness to Learn	Receptive	Teaching method	Discussion
Understanding	Good	Evaluation Method	Verbal
Follow-up	Content, No Follow-up Needed		

Clinical Note:

Reassessment

Assessment Sts Complete Collected DTime 08/29/2017 19:30
 Collected By Gwendolyn K Kelley, RN

Pt Name: [REDACTED] L
 Rm/ Bed:

MRN: 1116206
 Page 7 of 16

Assessment Report

ORE_0010_DSCH_NBR_V1.rpt v1.00

Printed By :Workflow

Printed On: 31-Aug-17 15:54

Assessment Report

Generated from 08/28/2017 00:00 to 09/01/2017 23:59

Pt Name:	██████████ L	MRN:	1116206
Pt ID:	0101757329	Acct No:	K20034006872
DOB:	10/01/2013	Age/Sex:	3Y/F
Adm DTime:	08/28/2017 01:18	Atn Dr:	Tran, Sharon MD
Nurs Sta:	S 5 East 1	Rm & Bed:	
Dx:			
Alrg:	codeine, Fish Containing Products, Fish containing products		

Reassessment

Assessment Sts	Complete	Collected DTime	08/29/2017 19:30
Collected By	Gwendolyn K Kelley, RN		

Reassessment

Temperature	97.9 F	Temperature Site	Temporal
Pulse	120	Pulse site	VS machine
Respirations	28	O2 Saturation (%)	95
Height	3/1 ft,in	How Obtained	Stated
Weight	36/15.897 lbs,oz	How Obtained	Measured
Body Mass Index	19.00	Ideal Body Weight, female	-14.86
Ideal Body Weight, male	-31.83		

Patient Location

Primary location	In their primary assigned location
------------------	------------------------------------

Pain / Sedation Assessment

No complaints of pain at this time	Yes	Total score	0
Face	No particular expression or smile	Legs	Normal position or relaxed
Activity	Lying quietly, normal position, moves easily	Cry	No cry
Consolability	Content, relaxed		

HEENT Assessment

Head	WDL	Eyes	WDL
Ears	WDL	Nose	WDL
Mouth	WDL	Throat	WDL

Respiratory Assessment

Oxygen	WDL	O2 Saturation (%)	95
Respiratory	WDL	Breath sounds within defined limits	WDL except
LUL	Coarse rales	LLL	Coarse rales
RUL	Coarse rales	RML	Coarse rales
RLL	Coarse rales		

Cardiovascular Assessment

Cardiovascular	WDL	Peripheral circulation	WDL
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Gastrointestinal Assessment

Gastrointestinal	WDL	Equipment	Pads / briefs
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Genitourinary Assessment

Pt Name: ██████████ L
Rm/ Bed:

MRN: 1116206
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Assessment Report

ORE_0010_DSCH_NBR_V1.rpt.v1.00

Printed By :Workflow

Printed On: 31-Aug-17 15:54

Assessment Report

Generated from 08/28/2017 00:00 to 09/01/2017 23:59

Pt Name: [REDACTED] L MRN: 1116206
 Pt ID: 0101757329 Acct No: K20034006872
 DOB: 10/01/2013 Age/Sex: 3Y/F
 Adm DTime: 08/28/2017 01:18 Atn Dr: Tran, Sharon MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Alrg: codeine, Fish Containing Products, Fish containing products

Reassessment

Assessment Sts Complete Collected DTime 08/29/2017 19:30
 Collected By Gwendolyn K Kelley, RN

Genitourinary Assessment

Genitourinary	WDL	Equipment	Pads / briefs
Urinary catheter present on admission	Not applicable	Indwelling Urinary Catheter present on admission	No
External genitalia	Deferred		

Musculoskeletal Assessment

Musculoskeletal	WDL	Bones and Joints	WDL
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Neurological Assessment

Eye opening	Spontaneous	Motor response	Moves spontaneously or purposefully
Verbal response	Smiles, oriented to sounds, follows objects, interacts	GCS Total Score	15
Neurological	WDL except	Oriented to	Person
Oriented to person, place and time	No	Behavior	Quiets easily
Motor function	WDL		

Integumentary Assessment

Integumentary	WDL		
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Braden Skin Risk Assessment

Mobility: Ability to change and control body position	No Limitations	Activity: Degree of physical activity	Walks Frequently
Sensory Perception:	Slightly Limited	Moisture	Occasionally Moist
Friction and shear	No Apparent Problem	Nutrition: Usual food intake pattern	Adequate
Tissue perfusion and oxygenation	Adequate	Modified Braden Score	24

Fall Risk Assessment

Age	Less than 3 years old	Gender	Female
Diagnosis	Alterations in oxygenation (respiratory diagnosis, dehydration, anemia, anorexia, syncope / dizziness, etc.)	Cognitive Impairment	Forgets limitations
Environmental Factors	Placed in bed	Response to Surgery/Sedation/Anesthesia	More than 48 hours / None
Medication Usage	Other medications / None	Humpty Dumpty score	14

Pt Name: [REDACTED] L

MRN: 1116206

Assessment Report

Rm/ Bed:

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ORE_0010_DSCH_NBR_V1.rpt v1.00

Printed By :Workflow

Assessment Report

Generated from 08/28/2017 00:00 to 09/01/2017 23:59

Pt Name: [REDACTED] L MRN: 1116206
 Pt ID: 0101757329 Acct No: K20034006872
 DOB: 10/01/2013 Age/Sex: 3Y/F
 Adm DTime: 08/28/2017 01:18 Attn Dr: Tran, Sharon MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Alrg: codeine, Fish Containing Products, Fish containing products

Reassessment

Assessment Sts Complete Collected DTime 08/29/2017 19:30
 Collected By Gwendolyn K Kelley, RN

Fall Risk Assessment

Fall risk level High risk Interventions Fall-precaution identifier implementation (yellow falls wrist band applied, fall risk ID magnet at door)

Education - Multidisciplinary

Nursing education topic	Medication	Description 1	prelone
Person educated	Family	Barriers to learning	None
Readiness to Learn	Receptive	Teaching method	Discussion
Understanding	Good	Evaluation Method	Verbal
Follow-up	No Follow-up Needed		

Clinical Note:

Reassessment

Assessment Sts Complete Collected DTime 08/29/2017 07:40
 Collected By Catrina J Lewis, RN

Reassessment

Height	3/1 ft,in	How Obtained	Stated
Weight	36/15.897 lbs,oz	How Obtained	Measured
Body Mass Index	19.00	Ideal Body Weight, female	-14.86
Ideal Body Weight, male	-31.83		

Patient Location

Primary location In their primary assigned location

Pain / Sedation Assessment

No complaints of pain at this time	Yes	Total score	0
Face	No particular expression or smile	Legs	Normal position or relaxed
Activity	Lying quietly, normal position, moves easily	Cry	No cry
Consolability	Content, relaxed		

HEENT Assessment

Head	WDL	Eyes	WDL
Ears	WDL	Nose	WDL
Mouth	WDL	Throat	WDL

Pt Name: [REDACTED] L

MRN: 1116206

Assessment Report

Rm/ Bed:

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ORE_0010_DSCH_NBR_V1.rpt v1.00

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Assessment Report

Generated from 08/28/2017 00:00 to 09/01/2017 23:59

Pt Name: [REDACTED] L MRN: 1116206
 Pt ID: 0101757329 Acct No: K20034006872
 DOB: 10/01/2013 Age/Sex: 3Y/F
 Adm DTime: 08/28/2017 01:18 Atn Dr: Tran, Sharon MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Alrg: codeine, Fish Containing Products, Fish containing products

Reassessment

Assessment Sts	Complete	Collected DTime	08/29/2017 07:40
Collected By	Catrina J Lewis, RN		
Respiratory Assessment			
Oxygen	WDL	Respiratory	WDL except
Cough	Non - productive	Breath sounds within defined limits	WDL except
LUL	Wheezes, expiratory, Wheezes, inspiratory	RUL	Wheezes, expiratory, Wheezes, inspiratory
RML	Wheezes, expiratory, Wheezes, inspiratory		
Cardiovascular Assessment			
Cardiovascular	WDL	Peripheral circulation	WDL
Gastrointestinal Assessment			
Gastrointestinal	WDL	Equipment	Pads / briefs
Genitourinary Assessment			
Genitourinary	WDL	Equipment	Pads / briefs
Urinary catheter present on admission	Not applicable	Indwelling Urinary Catheter present on admission	No
External genitalia	Deferred		
Musculoskeletal Assessment			
Musculoskeletal	WDL	Bones and Joints	WDL
Neurological Assessment			
Eye opening	Spontaneous	Motor response	Moves spontaneously or purposefully
Verbal response	Smiles, oriented to sounds, follows objects, interacts	GCS Total Score	15
Neurological	WDL except	Oriented to Behavior	Person
Oriented to person, place and time	No		Quiets easily
Motor function	WDL		
Integumentary Assessment			
Integumentary	WDL		
Braden Skin Risk Assessment			
Mobility: Ability to change and control body position	No Limitations	Activity: Degree of physical activity	Walks Frequently
Sensory Perception:	No Impairment	Moisture	Occasionally Moist
Friction and shear	No Apparent Problem		

Pt Name: [REDACTED] L
 Rm/ Bed:

MRN: 1116206
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Assessment Report

ORE_0010_DSCH_NBR_V1.rpt v1.00

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Printed On: 31-Aug-17 15:54

Assessment Report

Generated from 08/28/2017 00:00 to 09/01/2017 23:59

Pt Name: [REDACTED] L MRN: 1116206
 Pt ID: 0101757329 Acct No: K20034006872
 DOB: 10/01/2013 Age/Sex: 3Y/F
 Adm DTime: 08/28/2017 01:18 Attn Dr: Tran, Sharon MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Allrg: codeine, Fish Containing Products, Fish containing products

Reassessment

Assessment Sts Complete Collected DTime 08/29/2017 07:40
 Collected By Catrina J Lewis, RN

Braden Skin Risk Assessment

Nutrition: Usual food intake Adequate Tissue perfusion and oxygenation Excellent
 Modified Braden Score 26

Fall Risk Assessment

Age Less than 3 years old Gender Female
 Diagnosis Alterations in oxygenation (respiratory diagnosis, dehydration, anemia, anorexia, syncope / dizziness, etc.) Cognitive Impairment Not aware of limitations
 Environmental Factors Placed in bed Response to Surgery/Sedation/Anesthesia More than 48 hours / None
 Medication Usage Other medications / None Humpty Dumpty score 15
 Fall risk level High risk Interventions Fall-precaution identifier implementation (yellow falls wrist band applied, fall risk ID magnet at door)

Education - Multidisciplinary

Nursing education topic Safety Person educated Parent
 Barriers to learning None Readiness to Learn Receptive
 Understanding Good Evaluation Method Verbal
 Follow-up No Follow-up Needed

Clinical Note:

Reassessment

Assessment Sts Complete Collected DTime 08/28/2017 19:30
 Collected By Gwendolyn K Kelley, RN

Reassessment

Temperature 98.8 F Temperature Site Temporal
 Pulse 131 Pulse site VS machine
 Respirations 32 O2 Saturation (%) 97
 Height 3/1 ft,in How Obtained Stated
 Weight 36/15.897 lbs,oz How Obtained Measured
 Body Mass Index 19.00 Ideal Body Weight, female -14.86
 Ideal Body Weight, male -31.83

Patient Location

Pt Name: [REDACTED] L
 Rm/ Bed:

MRN: 1116206
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Assessment Report

ORE_0010_DSCH_NBR_V1.rpt v1.00

Printed By :Workflow

Printed On: 31-Aug-17 15:54

Assessment Report

Generated from 08/28/2017 00:00 to 09/01/2017 23:59

Pt Name: [REDACTED] L MRN: 1116206
 Pt ID: 0101757329 Acct No: K20034006872
 DOB: 10/01/2013 Age/Sex: 3Y/F
 Adm DTime: 08/28/2017 01:18 Atn Dr: Tran, Sharon MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Alrg: codeine, Fish Containing Products, Fish containing products

Reassessment

Assessment Sts	Complete	Collected DTime	08/28/2017 19:30
Collected By	Gwendolyn K Kelley, RN		
<u>Patient Location</u>			
Primary location	In their primary assigned location		
<u>Pain / Sedation Assessment</u>			
No complaints of pain at this time	Yes	Total score	0
Face	No particular expression or smile	Legs	Normal position or relaxed
Activity	Lying quietly, normal position, moves easily	Cry	No cry
Consolability	Content, relaxed		
<u>HEENT Assessment</u>			
Head	WDL	Eyes	WDL
Ears	WDL	Nose	WDL
Mouth	WDL	Throat	WDL
<u>Respiratory Assessment</u>			
Oxygen	WDL	O2 Saturation (%)	97
Respiratory	WDL except	Cough	Non - productive
Breath sounds within defined limits	WDL except	LUL	Wheezes, expiratory, Wheezes, inspiratory
RUL	Wheezes, expiratory, Wheezes, inspiratory	RML	Wheezes, expiratory, Wheezes, inspiratory
<u>Cardiovascular Assessment</u>			
Cardiovascular	WDL	Peripheral circulation	WDL
<u>Gastrointestinal Assessment</u>			
Gastrointestinal	WDL	Equipment	Pads / briefs
<u>Genitourinary Assessment</u>			
Genitourinary	WDL	Equipment	Pads / briefs
Urinary catheter present on admission	Not applicable	Indwelling Urinary Catheter present on admission	No
External genitalia	Deferred		
<u>Musculoskeletal Assessment</u>			
Musculoskeletal	WDL	Bones and Joints	WDL
<u>Neurological Assessment</u>			

Pt Name: [REDACTED] L
 Rm/ Bed:

MRN: 1116206
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Assessment Report

ORE_0010_DSCH_NBR_V1.rpt v1.00

Printed By :Workflow

Printed On: 31-Aug-17 15:54

Assessment Report

Generated from 08/28/2017 00:00 to 09/01/2017 23:59

Pt Name: [REDACTED] L MRN: 1116206
 Pt ID: 0101757329 Acct No: K20034006872
 DOB: 10/01/2013 Age/Sex: 3Y/F
 Adm DTime: 08/28/2017 01:18 Att Dr: Tran, Sharon MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 A/Rg: codeine, Fish Containing Products, Fish containing products

Reassessment

Assessment Sts Complete Collected DTime 08/28/2017 19:30
 Collected By Gwendolyn K Kelley, RN

Neurological Assessment

Eye opening	Spontaneous	Motor response	Moves spontaneously or purposefully
Verbal response	Smiles, oriented to sounds, follows objects, interacts	GCS Total Score	15
Neurological	WDL except	Oriented to	Person
Oriented to person, place and time	No	Behavior	Quiets easily
Motor function	WDL		

Integumentary Assessment

Integumentary WDL

Braden Skin Risk Assessment

Mobility: Ability to change and control body position	No Limitations	Activity: Degree of physical activity	Walks Frequently
Sensory Perception:	Slightly Limited	Moisture	Occasionally Moist
Friction and shear	No Apparent Problem	Nutrition: Usual food intake pattern	Adequate
Tissue perfusion and oxygenation	Adequate	Modified Braden Score	24

Fall Risk Assessment

Age	Less than 3 years old	Gender	Female
Diagnosis	Alterations in oxygenation (respiratory diagnosis, dehydration, anemia, anorexia, syncope / dizziness, etc.)	Cognitive Impairment	Not aware of limitations
Environmental Factors	Placed in bed	Response to Surgery/Sedation/Anesthesia	More than 48 hours / None
Medication Usage	Other medications / None	Humpty Dumpty score	15
Fall risk level	High risk	Interventions	Fall-precaution identifier implementation (yellow falls wrist band applied, fall risk ID magnet at door)

Education - Multidisciplinary

Nursing education topic	Medication	Person educated	Parent
Barriers to learning	None	Readiness to Learn	Receptive
Readiness to Learn	Refused education	Teaching method	Discussion
Understanding	Good	Follow-up	No Follow-up Needed

Pt Name: [REDACTED] L

MRN: 1116206

Assessment Report

Rm/ Bed:

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ORE_0010_DSCH_NBR_V1.rpt v1.00

Printed By :Workflow

Assessment Report

Generated from 08/28/2017 00:00 to 09/01/2017 23:59

Pt Name: [REDACTED] L MRN: 1116206
 Pt ID: 0101757329 Acct No: K20034006872
 DOB: 10/01/2013 Age/Sex: 3Y/F
 Adm DTime: 08/28/2017 01:18 Attn Dr: Tran, Sharon MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Alrg: codeine, Fish Containing Products, Fish containing products

Reassessment

Assessment Sts Complete Collected DTime 08/28/2017 19:30
 Collected By Gwendolyn K Kelley, RN

Clinical Note:

Reassessment

Assessment Sts Complete Collected DTime 08/28/2017 07:15
 Collected By Catrina J Lewis, RN

Reassessment

Height	3/1 ft, in	How Obtained	Stated
Weight	36/15.897 lbs, oz	How Obtained	Measured
Body Mass Index	19.00	Ideal Body Weight, female	-14.86
Ideal Body Weight, male	-31.83		

Patient Location

Primary location In their primary assigned location

Pain / Sedation Assessment

No complaints of pain at this time	Yes	Total score	0
Face	No particular expression or smile	Legs	Normal position or relaxed
Activity	Lying quietly, normal position, moves easily	Cry	No cry
Consolability	Content, relaxed		

HEENT Assessment

Head	WDL	Eyes	WDL
Ears	WDL	Nose	WDL
Mouth	WDL	Throat	WDL

Respiratory Assessment

Oxygen	WDL	Respiratory	WDL except
Respiratory pattern	Tachypnea	Cough	Non - productive
Breath sounds within defined limits	WDL except	LUL	Wheezes, expiratory, Wheezes, inspiratory
RUL	Wheezes, expiratory, Wheezes, inspiratory	RML	Wheezes, expiratory, Wheezes, inspiratory

Cardiovascular Assessment

Cardiovascular	WDL	Peripheral circulation	WDL
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Gastrointestinal Assessment

Gastrointestinal	WDL
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Pt Name: [REDACTED] L
 Rm/ Bed:

MRN: 1116206
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Assessment Report

ORE_0010_DSCH_NBR_V1.rpt v1.00

Printed By :Workflow

Printed On: 31-Aug-17 15:54

Assessment Report

Generated from 08/28/2017 00:00 to 09/01/2017 23:59

Pt Name: [REDACTED] L MRN: 1116206
 Pt ID: 0101757329 Acct No: K20034006872
 DOB: 10/01/2013 Age/Sex: 3Y/F
 Adm DTime: 08/28/2017 01:18 Atn Dr: Tran, Sharon MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Alrg: codeine, Fish Containing Products, Fish containing products

Reassessment

Assessment Sts Complete Collected DTime 08/28/2017 07:15
 Collected By Catrina J Lewis, RN

Genitourinary Assessment

Genitourinary	WDL	Urinary catheter present on admission	Not applicable
Indwelling Urinary Catheter present on admission	No	External genitalia	Deferred

Musculoskeletal Assessment

Musculoskeletal	WDL	Bones and Joints	WDL
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Neurological Assessment

Eye opening	Spontaneous	Motor response	Moves spontaneously or purposefully
Verbal response	Smiles, oriented to sounds, follows objects, interacts	GCS Total Score	15
Neurological	WDL	Oriented to person, place and time	Yes
Motor function	WDL		

Integumentary Assessment

Integumentary	WDL
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Braden Skin Risk Assessment

Mobility: Ability to change and control body position	No Limitations	Activity: Degree of physical activity	Walks Frequently
Sensory Perception:	No Impairment	Moisture	Rarely Moist
Friction and shear	No Apparent Problem	Nutrition: Usual food intake pattern	Adequate
Tissue perfusion and oxygenation	Adequate	Modified Braden Score	26

Clinical Note:

Pt Name: [REDACTED] L
 Rm/ Bed:

MRN: 1116206
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ALLERGY REPORT

Pt Name: [REDACTED] L MRN: 1116206
Pt ID: 0101757329 Acct No: K20034006872
DOB: 10/01/2013 Age/Sex: 3Y/F
Adm DTime: 08/28/2017 01:18 Atn Dr: Tran, Sharon MD
Nurs Sta: S 5 East 1 Rm & Bed:
Dx:
Alerg: codeine, Fish Containing Products, Fish containing products

Alerg Type	Alerg Name	Onset	Reaction	Severity	Comment
Drug	codeine	7/14/2017	Shortness of Breath	Severe	"Took codeine yesterday. Started wheezing, couldnt breathe like she was having an asthma attack"
Drug	Fish Containing Products	05/2017	Anaphylaxis	Severe	Patient severely allergic. Reaction when touches seafood
Food	Fish containing products	05/2017	Anaphylaxis	Severe	Patient severely allergic. Reaction when touches seafood

Pt Name: HENDERSON [REDACTED] L
Rm/ Bed:

MRN: 1116206
Page 1 of 1

Allergy Report
ORE_0109_DSCH_NBR.rpt v1.00
Printed By :Workflow
Printed On: 31-Aug-17 15:54

Charted Interventions Report

Generated from 08/28/2017 00:00 to 09/01/2017 23:59

Pt Name: [REDACTED] L MRN: 1116206
 Pt ID: 0101757329 Acct No: K20034006872
 DOB: 10/01/2013 Age/Sex: 3Y/Female
 Adm DTime: 08/28/2017 01:18 Atn Dr: Tran, Sharon MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Allrg: codeine, Fish Containing Products, Fish containing products

Scheduled Interventions

Service Type: Nursing

Service Sub Type: Activity

Order As Written: Bedrest with bathroom privileges

Order Status: Complete

Planned Start Date/Time	Actual Start Date/Time	Occurrence Status Modifier	Comment	Performed By	Supervised By
08/28/2017 03:17	08/28/2017 03:17	Complete		Meghan A Wallace, RN	

Service Type: Patient Care Orders

Service Sub Type: PCO Education

Order As Written: Education, fall prevention every 12 hr DAILY and PRN as needed

Order Status: Discontinue

Planned Start Date/Time	Actual Start Date/Time	Occurrence Status Modifier	Comment	Performed By	Supervised By
08/28/2017 04:31	08/28/2017 04:31	Complete		Meghan A Wallace, RN	
08/28/2017 16:31	08/28/2017 16:31	Complete		Meghan A Wallace, RN	
08/29/2017 04:31	08/29/2017 04:31	Complete		Gwendolyn K Kelley, RN	
08/29/2017 16:31	08/29/2017 16:31	Complete		Catrina J Lewis, RN	
08/30/2017 04:31	08/30/2017 04:31	Complete		Gwendolyn K Kelley, RN	

Order As Written: Education, position change every 12 hr DAILY and PRN as needed

Order Status: Discontinue

Planned Start Date/Time	Actual Start Date/Time	Occurrence Status Modifier	Comment	Performed By	Supervised By
08/28/2017 04:31	08/28/2017 04:31	Complete		Meghan A Wallace, RN	
08/28/2017 16:31	08/28/2017 16:31	Complete		Meghan A Wallace, RN	
08/29/2017 04:31	08/29/2017 04:31	Complete		Gwendolyn K Kelley, RN	

Pt Name: [REDACTED] L

MRN: 1116206

Charted Interventions Report

Rm/ Bed:

Page 1 of 3

ORE_0129_DSCH_NBR_V1.rpt v1.00

Printed By :

Printed On: 31-Aug-17 15:54

Charted Interventions Report

Generated from 08/28/2017 00:00 to 09/01/2017 23:59

Pt Name: [REDACTED] L MRN: 1116206
 Pt ID: 0101757329 Acct No: K20034006872
 DOB: 10/01/2013 Age/Sex: 3Y/Female
 Adm DTime: 08/28/2017 01:18 Atn Dr: Tran, Sharon MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Alrg: codeine, Fish Containing Products, Fish containing products

Planned Start Date/Time	Actual Start Date/Time	Occurrence Status Modifier	Comment	Performed By	Supervised By
08/29/2017 16:31	08/29/2017 16:31	Complete		Catrina J Lewis, RN	
08/30/2017 04:31	08/30/2017 04:31	Complete		Gwendolyn K Kelley, RN	

Order As Written: Education, asthma exacerbation prevention Nurse to call Asthma Taskforce, Kim Donelson NP at Dr.Jones' office

Order Status: Complete

Planned Start Date/Time	Actual Start Date/Time	Occurrence Status Modifier	Comment	Performed By	Supervised By
08/28/2017 14:21	08/28/2017 14:21	Complete		Catrina J Lewis, RN	

Service Sub Type: PCO Treatments

Order As Written: Environmental safety management every 12 hr DAILY and PRN as needed

Order Status: Discontinue

Planned Start Date/Time	Actual Start Date/Time	Occurrence Status Modifier	Comment	Performed By	Supervised By
08/28/2017 04:31	08/28/2017 04:31	Complete		Meghan A Wallace, RN	
08/28/2017 16:31	08/28/2017 16:31	Complete		Meghan A Wallace, RN	
08/29/2017 04:31	08/29/2017 04:31	Complete		Gwendolyn K Kelley, RN	
08/29/2017 16:31	08/29/2017 16:31	Complete		Catrina J Lewis, RN	
08/30/2017 04:31	08/30/2017 04:31	Complete		Gwendolyn K Kelley, RN	

Order As Written: Head of bed elevation every 12 hr DAILY and PRN as needed

Order Status: Discontinue

Planned Start Date/Time	Actual Start Date/Time	Occurrence Status Modifier	Comment	Performed By	Supervised By
08/28/2017 04:31	08/28/2017 04:31	Complete		Meghan A Wallace, RN	
08/28/2017 16:31	08/28/2017 16:31	Complete		Meghan A Wallace, RN	
08/29/2017 04:31	08/29/2017 04:31	Complete		Gwendolyn K Kelley, RN	
08/29/2017 16:31	08/29/2017 16:31	Complete		Catrina J Lewis, RN	
08/30/2017 04:31	08/30/2017 04:31	Complete		Gwendolyn K Kelley, RN	

Pt Name: [REDACTED] L

MRN: 1116206

Charted Interventions Report

Rm/Bed:

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ORE_0129_DSCH_NBR_V1.rpt v1.00

Printed By:

Printed On: 31-Aug-17 15:54

Charted Interventions Report

Generated from 08/28/2017 00:00 to 09/01/2017 23:59

Pt Name:	██████████ L	MRN:	1116206
Pt ID:	0101757329	Acct No:	K20034006872
DOB:	10/01/2013	Age/Sex:	3Y/Female
Adm DTime:	08/28/2017 01:18	Attn Dr:	Tran, Sharon MD
Nurs Sta:	S 5 East 1	Rm & Bed:	
Dx:			
Alrg:	codeine, Fish Containing Products, Fish containing products		

Pt Name: ██████████ L
Rm/ Bed:

MRN: 1116206
Page 3 of 3

Charted Interventions Report
ORE_0129_DSCH_NBR_V1.rpt v1.00
Printed By :
Printed On: 31-Aug-17 15:54



WILLIS-KNIGHTON HEALTH SYSTEM

PEDIATRIC SECURITY INFORMATION SHEET

Dear Parent,

Welcome to Willis-Knighton Health System. Your child's safety is a priority at Willis-Knighton. You can help ensure your child's safety by following these important steps:

1. A responsible adult should be with a child 12 years or younger at all times.
2. Become familiar with hospital personnel. Employees handling your child wear galaxy blue scrubs, lab coat/pediatric theme jacket and a hospital badge with their picture on it. Please take time to notice whether the photo on the badge and the staff member's face are the same. If they are not, notify the nurse's station immediately!
3. Pediatric patients must have an identification band on the wrist or foot at all times.
4. All Pediatric Nursing staff wear:
 - a. galaxy blue scrubs and lab jacket with pediatric theme
 - b. a WKHS ID badge with their picture on it.
5. **Never leave your child alone or unsupervised in your room.** Also, keep your door to your room closed at all times.
6. Feel free to question anyone who comes into your room. Alert the nurse's station immediately, even if the person is dressed in hospital clothing or seems to have a good reason for being there.
7. Never allow your child to leave their room with a staff member unless your nurse introduces that staff member to you. We want you to accompany your child to special procedures that are done off the unit. The nurse will inform you of what procedures that you will not be allowed to be in with your child. Example: You may accompany your child to the outside doors of surgery but will not be allowed in surgery.

Willis-Knighton Health System is dedicated to keeping your child safe and secure. If you have any questions or concerns about our Pediatric Security Policy, please contact your nurse.

SIGNATURE: _____

WITNESS: _____

DATE/TIME: _____

Janif Alsh
Y. E. Miller
8/28/17 0440



M10005



Printed: 08/28/2017

IN981 Revised 12/08

10/01/2013 003Y 10M F
Paul, Edward M.D.
K20034006872 08/28/2017 S5517 A



Asthma Education Record

Functional Assessment Learning Barriers <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Communication Barriers <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Comprehension Barriers <input type="checkbox"/> Written <input type="checkbox"/> Verbal <input checked="" type="checkbox"/> None Learning Techniques <input checked="" type="checkbox"/> Written <input checked="" type="checkbox"/> Verbal <input checked="" type="checkbox"/> Demonstration Current Medications Controller <u>A1b nebs + HFA ;</u> <u>Controller</u> Quick Relief <u>A1b nebs + HFA</u> Other _____ _____ _____	Learner <input type="checkbox"/> Patient <input checked="" type="checkbox"/> Parent <u>Mother</u> <input type="checkbox"/> Family _____ <input type="checkbox"/> Other _____ Evidence of Learning <input checked="" type="checkbox"/> Verbalizes understanding of information presented <input checked="" type="checkbox"/> Provided return demonstration of delivery device <input type="checkbox"/> Need further follow up education
---	--

Education Provided

	Education	Yes	No
1.	Educated on disease process of asthma	✓	
2.	Educated on controller medication	✓	
3.	Educated on quick relief medication	✓	
4.	Educated on aerochamber technique	✓	
5.	Educated on compressor/nebulized medications	✓	
6.	Education of triggers and trigger avoidance	✓	
7.	Asthma Action Plan provided	✓	
8.	School Medication Form provided <u>mother denies need</u>		✓

Comments Mother reports twice weekly use of Albuterol, hospital + ER visits
within the past year. Would recommend controller therapy + mom
is agreeable to flu = peds pulm.

Shari Dineson CRP

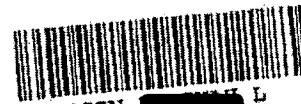
Signature

8/29/17 1130

Date/Time

Shari Dineson CRP

Printed Name/Credential

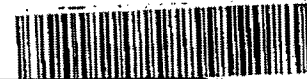


HENDERSON, [REDACTED] L
 10/01/13 3Y 10M
 Tran, Sharon N M.D. S5517
 K20034006872 08/28/17



NS0025

Spacer and Nebulizer Cleaning



10/01/13 3Y 10M AH L
Tran, Sharon N M.D. S5517
K20034006872 08/28/17

Spacer:

Cleaning

- After each use wipe or rinse the mouthpiece or mask well

Weekly

- Take spacer and mask apart, soak and stir gently in mild (non-antibacterial) dish detergent and lukewarm water
- Rinse well with clean water, shake out excess water and allow to air dry before reassembling

If Patient is sick

- Disinfect daily by soaking in 70% isopropyl alcohol for 5 minutes, then rinse well and air dry

OR

- 3% hydrogen peroxide for 30 minutes, then rinse well and air dry

Disposable Nebulizers (updraft nebs):

Cleaning

- After every treatment rinse the nebulizer to remove medication

At end of day

- Hand-wash with lukewarm water and mild (non-antibacterial) soap and rinse well with clean water

Once a week OR daily while sick

- Disinfect by soaking in 70% isopropyl alcohol for 5 minutes then rinse well and air dry

Or:

- 3% hydrogen peroxide for 30 minutes then rinse well and air dry

Compressor

- Mail in any warranty or registration that may come with a new compressor
- Keep all information about your compressor, including when and where it was purchased, most have a 5 year warranty
- Change or clean compressor filters following manufactures recommendations
- Wipe clean daily after use

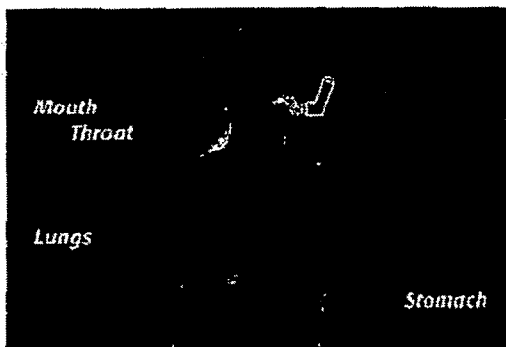


10/01/13 3Y 10M
Tran, Sharon N M.D. S5517
X20034006872 08/28/17 SPACER WITH MASK



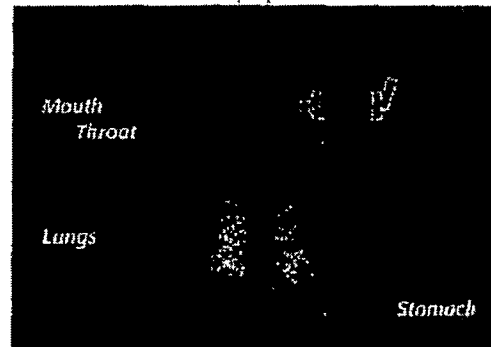
1. Remove plastic cap from the inhaler (MDI) and spacer and shake well
2. If this is the first time using the inhaler then prime it by spraying it into the air 2 times before use
3. Insert the mouth piece of the inhaler into the back of the spacer remove spacer cap and shake well
4. Gently but firmly cover the mouth and nose with mask making sure to have a complete seal
5. Press down on the inhaler once, this will allow 1 puff of medication into the spacer watch as the patient takes 5-6, as deep as possible, breaths before removing the spacer
6. Wait for 30 seconds to 1 minute then repeat above steps according to providers instructions
7. **If using inhaled steroids it is very important to rinse or wipe out the mouth with a wet rag and also wipe the face with a wet rag... (DO NOT SWALLOW THE WATER) this will help prevent a yeast infection in the mouth, throat and on the face
8. To clean spacer, take apart and wash all in mild soapy warm water, rinse well and air dry
9. Check counter on MDI, when at 20 it is time for a refill

Why use a Spacer with an Inhaler?



Inhaler alone

When an inhaler is used alone, medicine ends up in the mouth, throat, stomach and lungs.



Inhaler used with spacer device

When an inhaler is used with a spacer device, more medicine is delivered to the lungs.



WILLIS-KNIGHTON
HEALTH SYSTEM

Discharge Instructions

Patient Name: [REDACTED] MRN / CID: 1116206
Date of Birth: 10/1/2013 Account Number: K20034006872
Date Admitted: 2017-Aug-28 01:18 AM Age / Sex: 4 / F
Location: S 5 East 1 S5517A Attending Physician: Tran Sharon MD
Allergies: codeine, Fish Containing Products, Fish containing products

Vital Signs:

Temperature: 98.5 Pulse: 105 Respirations: 26 Blood Pressure:

Gastrointestinal

Date of last bowel movement: 8/30/17

Medical Referrals

Name	When	Contact Number
PCP at UH	3-4 days	
Dr. Jones, Peds Pulmonology	as scheduled	

Restrictions

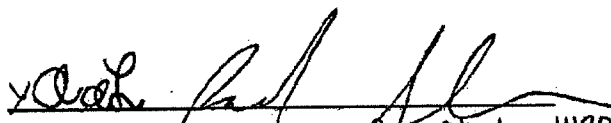
Diet: Pediatric Enteral Feeding Type

Activity: No Activity Restrictions Other:

Activity Instructions Stairs:

Discharge Instructions

Notify Physician For Fever or chills, Shortness of breath, If symptoms worsen contact your health care provider or call 911


Patient / Representative Date/Time 8/30/17 1420

 8/30/17 1420
Witness Signature Date / Time



**WILLIS-KNIGHTON
HEALTH SYSTEM**

Discharge Instructions

Patient Name: [REDACTED] L MRN / CID: 1116206
Date of Birth: 10/1/2013 Account Number: K20034006872
Date Admitted: 2017-Aug-28 01:18 AM Age / Sex: 4 / F
Location: S 5 East 1 S5517A Attending Physician: Tran Sharon MD
Allergies: codeine, Fish Containing Products, Fish containing products

Discharge Medication Reconciliation Report

Discharge Rec Status: Complete Collected On: 8/30/2017 2:07:10PM By: Sharon Nhu Tran, MD

Take these Medications

- ☒ prednisolONE 15 mg/5 mL Solution
Directions: 5 mL oral twice a day
Additional Instructions: for 3 days
Last Dose Given Date: _____ Time: _____
Retail Pharmacy: ePrescribed Mail Order Pharmacy: _____
Entered By: Sharon Nhu Tran, MD
- ☒ albuterol sulfate 2.5 mg/3 mL (0.083 %) Solution for Nebulization
Directions: 3 mL by inhalation every four hours as needed for Wheezing
Additional Instructions:
Last Dose Given Date: _____ Time: _____
Retail Pharmacy: ePrescribed Mail Order Pharmacy: _____
Entered By: Sharon Nhu Tran, MD
- ☒ albuterol sulfate (Proventil HFA) 90 mcg HFA Aerosol Inhaler
Directions: 2 puff by inhalation every four hours as needed for shortness of breath
Additional Instructions: Use with aerochamber
Last Dose Given Date: _____ Time: _____
Retail Pharmacy: ePrescribed Mail Order Pharmacy: _____
Entered By: Sharon Nhu Tran, MD

Pharmacy Information

Walgreens Drug Store 09492

Retail

3100 N MARKET ST
SHREVEPORT, LA 711074005
Phone #: 3186811083

Fax #: 3186819522



ASSIGNMENT OF BENEFITS

1. Hospital Care Consent: I/we consent to hospital services, treatment and diagnostic procedures by the hospital as may be deemed necessary or advisable by my physician and/or consultants selected by my physician. The consent to hospital care includes permission for x-ray examinations, laboratory procedures, I.V. treatments, hepatitis test administration of blood and blood products, injections, medications, recording, filming or video monitoring for internal purposes only, and hospital services rendered the patient under the general and special instruction of doctors. The patient acknowledges responsibility for any or all of these procedures. It is the hospital policy that the patient has the opportunity to discuss surgery and procedures with the patient's doctor before hand. The patient has the right to consent to surgery and procedures. Except in emergencies or unusual circumstances, the hospital does not allow its facilities to be used without this discussion and patient's consent. I voluntarily give my consent to hospital care and accept the condition of hospitalization listed.

2. Authorizations for Release of Information: The employees and agents of this hospital and copy services and electronic claims processing services under contract with this hospital and any third party billing agents for this hospital or any of its staff physicians involved with patient care are given permission to release any and all information relating to the patient, including but not limited to the medical record of the patient's hospitalization, to another healthcare provider if the patient was transferred to that facility from this hospital and to any and all insurance companies or other third-party paying or obligated to pay, in whole or in part, the charges incurred by the patient in this hospital; and they are also given permission to release the above described information to any agent or firm working for or with the above described insurance companies or other third-party payors for the purpose of performing pre-certification, concurrent and/or retrospective review and/or other utilization review of any kind.

3. Valuables: I understand and acknowledge that the hospital assumes no responsibility for personal possessions including cash, jewelry, bridgework, eyeglasses or any other personal possession which I choose to keep in my room. I have been advised that such valuables should be placed in the care of my family or deposited in the hospital vault located in the Business Office.

4. Safety Code for Hospital: Safety Codes for hospitals issued by the National Fire Protection Association prevent the use in the hospital of any electrical equipment or accessories until they have been safety checked by the hospital's electrical engineer. Exceptions to this rule are hair and blow dryers, curling irons, hot rollers, radios, clocks, electric razors, shavers, contact lens sterilizers, electric toothbrushes and calculators.

5. Payment Guaranty and Assignment of Insurance Benefits: I, the undersigned patient, guardian, and/or guarantor (hereinafter "Debtor") hereby promise to pay in full Willis-Knighton Health System (WKHS) customary charges for the goods and services rendered to the patient identified on the reverse side hereof during this period of hospitalization (hereinafter "Indebtedness"). Debtor acknowledges and agrees that, unless waived in full by WKHS as set forth below, the Indebtedness accruing during this hospitalization is due and payable in such amounts and at such times during this hospitalization as WKHS may, in its sole discretion, determine, that the entire Indebtedness is due and payable in full at discharge. I acknowledge that, upon proof of acceptable insurance coverage, WKHS, in its sole discretion, may reduce the amount of indebtedness due and payable during this hospitalizations and the balance due at discharge. In such event, I understand that all deductibles, co-insurance, non-covered charges and other items not paid by insurance or other third-party payors shall be due and payable during this period of hospitalization and upon discharge as set forth hereinabove. I acknowledge and agree that in the event that WKHS, in its sole discretion, accepts proof of insurance coverage, claims for payment for benefits will be filed on behalf of the Debtor and/or the insured and that these benefits will be considered by WKHS in determining the amounts due as set forth hereinabove. I understand and agree that WKHS will accept payments from third-party payors and insurers on behalf of the Debtor and apply such payment to the indebtedness to the extent that they are received. I acknowledge and agree that the filing of such insurance and other third-party claims is performed as a service by WKHS and in no way relieves me of the obligation to pay the Indebtedness as agreed herein above.

Patient hereby appoints WKMC as Patient's authorized representative to file any necessary claim appeal(s) on Patient's behalf. In consideration for this appointment, WKMC agrees only to collect only applicable copayments, deductibles, and coinsurance for covered benefits from the Patient and waives any right to collect any other payments related to those covered benefits from the Patient.

Debtor hereby absolutely assigns to WKHS all insurance benefits on all policies of insurance under which Debtor is an insured, whether hospital, medical, liability or other insurance, and also hereby absolutely assigns to WKHS the proceeds of any judgment or settlement of any claim against any third party and any and all other amounts which may be determined in any manner to be payable to Debtor in connection with any injury suffered by the patient which gives rise to the Indebtedness incurred during this period of treatment. I hereby authorize WKHS to obtain any and all information related to such injuries, including, but not limited to, accident reports and agree to cooperate with WKHS in connection with the procurement of any information or documents WKHS deems in its sole discretion, necessary or appropriate in connection with the assignment made pursuant to this paragraph. I hereby authorize and direct that all such payments and proceeds shall be made directly to WKHS under the terms of this assignment. Any receipts from WKHS shall be applied towards Indebtedness but such application shall not relieve the Debtor from the Debtor's obligation to pay any remaining portion to the Indebtedness. Debtor acknowledges and agrees that, to the extent that the Indebtedness has not been satisfied by such receipts, that portion of the Indebtedness for which payment has been deferred pursuant to the preceding paragraph shall be due and payable in full on the thirtieth day following the date of service. In the event that WKHS receives proceeds and/or payments in excess of the Indebtedness, WKHS may apply such excess payment to any outstanding Indebtedness of Debtor to WKHS arising out of any other period(s) of treatment as well as any attorneys' fees and expenses for which Debtor may be liable hereunder. In the event that all Indebtedness has been paid

Admission Date: 08/28/17

Admission Time: 0118



AM0005



10/01/13 3Y F
Paul, Edward M.D.
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ASSIGNMENT OF BENEFITS

12

in full, then WKHS will refund the Debtor any such excess payment. Notwithstanding anything herein to the contrary, the assignments made hereby shall remain in full force and effect until the entire Indebtedness and any and all attorneys' fees and expenses for which Debtor may be liable have been paid in full. In the event that the Indebtedness is not paid when and as due as determined by WKHS hereunder, and the Indebtedness is placed in the hands of an attorney for purposes of collection, Debtor agrees to pay reasonable attorneys' fees, which are hereby acknowledged to be one-third (1/3) of the amount of the Indebtedness at the time the matter is placed in the hands of an attorney, plus any and all court costs and other expenses incurred in connection with the collection of the Indebtedness.

Financial assistance is available to all patients who meet the requirements of our charity care policy. Patients are encouraged to contact the Business Office if they have any concerns or need assistance in paying their bills. Our charity care policy is limited to hospital charges and does not include physician, anesthesiologist or professional charges that are not billed by the hospital. In addition, financial assistance is not offered for cosmetic, elective, experimental or other treatments and all hospital services must be ordered by your physician.

6. Assignment to Physicians: I understand that my physician as well as other physicians who treat me or otherwise involved in my care while a patient at the hospital are not employees or agents of the hospital and the hospital is not responsible for their actions. I further understand that my physician or other physicians will send me a separate bill for their services, in addition to the hospital bill. I hereby assign to all physicians who treat me the benefits due to me for these services covering medical and/or surgical expenses. I agree that should be the amount be insufficient to cover the entire medical/surgical expense, I will be responsible to said physicians for payment of the entire bill.

7. Medicare Consent: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act (SSA) is correct. I authorize Willis-Knighton Health System (WKHS) to provide (SSA) or its intermediaries with access to my medical/hospital record for the purpose of processing the Medicare claim for this or a related Medicare claim. I further request that WKHS provide such copies thereof as may be requested. Copies may be made by WKHS or its agents or contractors providing copy service and electronic claims processing services and said third party billing agents for hospital and staff physicians involved with patient care.

8. Champus/Medicare Notice: Champus/Medicare will not pay for private rooms unless medical justified, personal convenience items, diagnostic admissions or test or hospital stays not medically necessary. My signature below acknowledges my receipt of this information regarding Champus/Medicare from the hospital on the date indicated.

9. Willis-Knighton Health System (and our Medical Staff) will use and disclose your personal health information to treat you, to receive payment for the care we provide and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website and have copies available for distribution. I acknowledge that I have received a copy of the Notice of Privacy Practices.

This form has been fully explained to me. My signature reflects my understanding of the information contained herein. I further understand and acknowledge that all references to myself as the patient shall be deemed to apply as if rewritten in their entirety to a dependent for whom I am responsible for and/or who is unable to consent on their behalf for reasons indicated below.

I acknowledge that I have been informed of my rights and obligations as a patient.

 _____ Signature of Patient/Guardian	_____ Date/Time	 _____ Guarantor	_____ Date/Time	 _____ Witness	_____ Date/Time
 _____ Print Name		 _____ Print Name		 _____ Print Name	

If Patient/Guarantor is unable to sign, I, _____, do hereby state that I have been given the authority to sign for

_____, either expressed or implied and that he or she is fully aware of this authority.

_____ Signature of Authorized Party	_____ Authorized Party's Relationship to the Patient	_____ Date/Time	_____ Witness	_____ Date/Time
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Admission Date: 08/28/17
Admission Time: 0118



AM0005



10/01/13 3Y F
Paul, Edward M.D.
K20034006872 08/28/17

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Is the Patient Here for Pre Op Testing: N Comment: Language Preferred for Medical Communication: ENGLISH Notice Given: Y Date Notice Given: 201409 Reason for Visit: BREATHIUNG DIFFICULTY						Admit Clerk: KINNEW1.A Device Id: Ethnicity: NHILAT																																																																																																																																																																																																										

WK South Hospital
K20033856236

S5E1S5504A
Sharon N Tran, M.D.

Report Type: SUMM

ADMITTED: 07/15/2017
DISCHARGED: 07/16/2017

Aaliyah is a 3-year-old female who was admitted to the pediatric service for acute respiratory distress. She has a past medical history significant for asthma and autism. Her grandmother reports that she developed cough two days prior to admission. At that time, she was seen at Willis-Knighton South ER and diagnosed with bronchitis and acute otitis media. A chest x-ray was done which was negative and she received Rocephin for her otitis media and was prescribed Amoxicillin and Tylenol with codeine and discharged home. Her grandmother reports the following day her wheezing worsened and when she was given Tylenol with codeine, she developed labored breathing and was taken back to the ER for evaluation. In the ER, she was tachypneic with respirations in the 30s, oxygen saturation 91%. During her admission, Aaliyah received Albuterol nebulizations, IV steroids, and IV fluids. She improved clinically and remained on room air and her respiratory distress resolved. A repeat chest x-ray was done in the ER which was also negative, did not show any infiltrates. Aaliyah was discharged home on 7/16/17 on the day of discharge. She was interactive and babbling, tolerating a regular diet, and was not in any respiratory distress. On exam, her tympanic membranes were dull bilaterally without any bulging. Her chest on auscultation had some scattered rhonchi but good aeration bilaterally and no wheezing and was unlabored. She was discharged home on Albuterol nebulizations every 4 hours for 24 hours and then as needed for wheezing and she will complete her amoxicillin course. It was discussed at length with her family to discontinue codeine, that it is not recommended in children and her respiratory distress was likely contributed to the codeine ingestion. She will follow up with her pediatrician.

DISCHARGE DIAGNOSES:

1. ACUTE RESPIRATORY DISTRESS.
2. UPPER RESPIRATORY INFECTION.
3. ACUTE OTITIS MEDIA.
4. ACUTE ASTHMA EXACERBATION.
5. CODEINE INGESTION.

Sharon N Tran, M.D.

PHYS: 002944
DICT DATE: 07/16/2017 03:41 P
TRANS DATE: 07/19/2017 12:25 P

WK South Hospital
K20033856236

S5E1S5504A
Sharon N Tran, M.D.

Report Type: SUMM

BY: ss
DISCHARGE SUMMARY
JOB #2344160

**Electronically Signed by: TRAN, SHARON NHU M.D. on 24-Jul-2017
11:00:12 -05:00**



WILLIS-KNIGHTON HEALTH SYSTEM

Pediatric Hospitalist History and Physical

Patient Name: _____ Date: 7/16/17 Time: _____

PCP: LSU Source of Information: MGM

Chief Complaint: SIB

History of Present Illness: _____

3 y/o female in PMH for asthma presented to VKS ER
w/ labored breathing. AM reports pt developed cym 2 days
ago. She has been at VKS ER at that time & Dr. E. Brundage
& Mom. She received Rocephin x1 for AM & Rx Amoxicillin &
Tylenol & Codeine. & D/C home. CXR ⊖

GM reports the following day, pt is wheezing & not well & she
developed labored breathing after they gave her the Tylenol &
codeine. She returned to ER for eval.

In ER, pt tachypneic RR: 30s & SpO₂: 91 RA
Ø Run Ø v/d Ø ↓ appetite

Past Medical/Birth History: ☐ Unremarkable ☒ Other Asthma, Autism

Past Surgical History: Ø

Allergies: ☐ NKDA ☒ Other School, Codeine

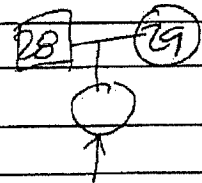
Immunizations: ☒ UTD ☐ Other _____

Family History: ☐ Noncontributory ☐ Other _____

Social History: ☒ Lives at home with parents ☐ Attends school _____

☒ Other lives to Mormon

Home Medications: Albuterol prn



HP0005

L7 URBIG, ANNE M M.D. 03304
K20033856236 07/15/17



LIYAH L
10/01/13 3Y 09M



Pediatric Hospitalist History and Physical continued

General: ☒ None ☐ Fever ☐ Decreased appetite/oral intake ☐ Decreased activity ☐ Fussy ☐ Other _____

HEENT: ☒ None ☐ Head injury ☐ Red/Swollen eyes ☐ Eye d/c ☐ Runny nose ☐ Congestion ☐ Earache ☐ Ear d/c
☐ Sore throat ☐ Other _____

Cardiovascular: ☒ None ☐ Cyanosis ☐ Chest pain _____

Respiratory: ☐ None ☒ Cough ☒ SOB ☒ Wheeze ☐ Other _____

GI: ☒ None ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Abd pain ☐ Bloody stools ☐ Other _____

Hematology: ☒ None ☐ Easy bruising ☐ Epistaxis ☐ Other _____

Neuro: ☒ None ☐ Headache ☐ Syncope ☐ Seizures ☐ LOC ☐ Other _____

GU: ☒ None ☐ Decreased urine ☐ Dysuria ☐ Discharge ☐ Other _____

Physical Exam: ☒ 10 systems reviewed and per History of Present Illness otherwise negative

Vitals: Temp 98.6 HR 125 RR 22 O2 sat 99 RA Wt 15.8 kg

General: ☒ Well-hydrated ☒ WN ☒ NAD ☒ Nontoxic ☐ Remarks bulging, heary

HEENT: ☒ Normocephalic atraumatic ☐ Anterior fontanelle open & flat ☒ PERRL ☒ Conjunctiva clear
☒ No rhinorrhea/congestion ☐ Nasal flaring ☒ Tympanic membranes normal bil ☒ Oral mucosa moist ☒ Pharynx normal
☐ Remarks B/L dull bulging

Neck: ☒ Normal ☒ Supple ☒ No rigidity ☐ Adenopathy ☐ Masses ☐ Jugular vein distention
☐ Remarks _____

Heart: ☒ Normal ☒ S1S2 ☐ RRR ☐ Murmur ☐ Remarks _____

Lungs: ☐ Normal ☐ CTA bil ☒ Unlabored Air movement: ☒ good ☐ fair ☐ poor ☐ Wheeze (end expiratory/inspiratory)
☒ Remarks few crackles scattered bilaterally

Abdomen: ☒ Normal ☒ Soft ☒ Non-tender ☒ Non-distended ☒ Normal active bowel sounds ☐ Hepatosplenomegaly
☐ Masses ☐ Remarks _____

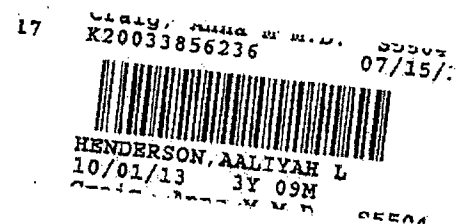
Extremities: ☒ Normal ☐ Cyanosis ☒ Capillary refill less than 2 seconds ☐ Edema ☐ _____ Pulses
☐ Remarks _____

Musculoskeletal: ☒ Normal ☐ Joints full ROM ☐ Pain ☐ Contractures ☐ Weakness ☐ Remarks _____

Skin: ☒ Normal ☐ Rash ☐ Remarks _____

Neuro: ☒ Normal/nonfocal ☒ Awake ☒ Alert ☐ Oriented ☐ Times 3 ☐ Irritable ☐ Sedated ☐ CN 2-12 intact
☐ Remarks _____

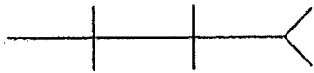
GU: ☒ Normal male/female genitalia ☐ Testes descended: ☐ Right ☐ Left ☐ Deferred
☐ Remarks _____



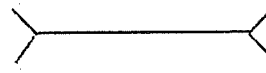


Pediatric Hospitalist History and Physical continued

LAB: ☐ Reviewed ☐ Abnormals



Ca _____
Alb _____ AstAlt _____
Alk/Phos _____
T/Dbili _____



Segs _____
Bands _____
Lymphs _____

☒ CXR Pneumonia ☐ Cultures _____

Other: Flu

Plan:

- ☒ See orders ☒ Continue medical management ☒ Follow labs ☒ O2, Respiratory Therapy
☒ IV Fluids Discussed assessment & plan with ☐ Patient ☒ Family

☐ IV antibiotics: _____

☐ Consults: _____

☐ Remarks: 3yo c URI, acute onset exacerbation, w/ acute resp distress, cough

☐ Extended time spent counseling patient and family AMM. D/C Improved clinically, Afebrile,

☐ Total time spent _____ minutes.

☐ Face to face _____ minutes.

[Signature]

Physician Signature

7/16/17 3pm
Date/Time

☒ Sharon Tran, M.D. (2944)

☐ Greg Oji, M.D. (2977)

☐ Craig Chu, MD (3101)

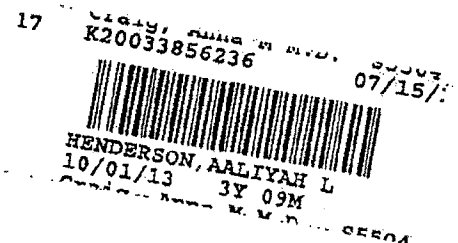
☐ Anna Craig, MD (3110)

#2344160

Discharge to Family to discuss
Discontinue Afebrile. Recommended
to not give children acetaminophen.
Family understands. D/C home.
Advise on Albuterol, complete Amoxicillin
course. Supportive care. Flu c PAP.



HP0005



Willis Knighton South

Name: Aaliya [REDACTED]

Age: 3 yrs Sex: Female DOB: 10/01/2013

Arrival Date: 07/15/2017 Arrival Time: 08:34

MRN: 1116206

Account#: K20033856236

**EMERGENCY DEPARTMENT
HOME MEDICATION RECONCILIATION**

Allergies: SEA FOOD

	Home Medication	Route	Dose	Frequency	Last Dose
1	albuterol sulfate 1.25 mg/3 mL	Inhl		as needed	
2	amoxicillin 250 mg/5 mL	PO	10 mL	every 12 hours	
3	codeine sulfate 15 mg/2.5 mL (2.5 mL)	PO	2.5 mL	every 4 hours as needed	

Administered Medications:

Time	Drug & Dose <i>Dispensable & Quantity</i>	Volume	Route	Rate	Infused Over	Site	Delivery	Staff
07/15 09:06	Orapred 1.5 tsp		PO					smc
12:15	Follow up: Response: No Adverse Reaction; Tolerated well							cph
09:06	Albuterol 0.5 unit dose		Inhalation					smc
09:23	Follow up: Response: No Adverse Reaction; Tolerated well							cph
09:24	Albuterol 0.5 unit dose		Inhalation					cph
12:14	Follow up: Response: No Adverse Reaction; Tolerated well							cph
11:54	Albuterol 0.5 unit dose		Inhalation					smc
12:54	Follow up: Response: No Adverse Reaction; Tolerated well							cph

Prescriptions:

Prescription	Custom Text
(Nothing entered)	

DISCHARGE INSTRUCTIONS

Change Home Meds as Follows

ALL ORDERED MEDICATIONS MUST
BE WRITTEN ON HOSPITAL ORDER
SHEET.THIS DOCUMENT IS NOT
A PHYSICIAN ORDER SHEET

Nurse's Notes

Name: Aaliyah [REDACTED]
Age: 3 yrs Sex: Female DOB: 10/01/2013
Arrival Date: 07/15/2017 Time: 08:34
Bed 13

Willis Knighton South

MRN: 1116206
Account#: K20033856236
Private MD:

Presentation:

07/15 Preferred language for medical communication is English. Presenting complaint: Mother states: She was 08:35 seen for a cold here yesterday and an ear infection. She was given Amox and Codeine and she is way worse today. Pt retracting and coughing in triage. Person Transporting: Parent. Transition of care: patient was not received from another setting of care. Mechanism of Injury: denies injury. Care prior to arrival: None.

08:41 Acuity: 2 - Emergent. dgg

08:45 Method of Arrival: Carried. dgg

Triage Assessment:

08:35 **General:** Appears well developed, well nourished, well groomed, Behavior is appropriate for age, pleasant, crying. dgg

08:35 **Pain:** level that is acceptable is 0 out of 10 on a pain scale. FACES pain scale score is 7 out of 10. dgg

Historical:

- **Allergies:** SEA FOOD;
- **Home Meds:**
 1. albuterol sulfate 1.25 mg/3 mL Inhl nebu as needed
 2. amoxicillin 250 mg/5 mL PO susr 10 mL every 12 hours
 3. codeine sulfate 15 mg/2.5 mL (2.5 mL) PO soln 2.5 mL every 4 hours as needed

• **PMHx:** Asthma

• **PSHx:** None

Historical:

08:48 Family history: No immediate family members are acutely ill. Immunization history: Childhood immunizations up to date. Social history: The patient lives at home with family the patient is a minor. Code Status: Full code. smc

08:51 The history from nurses notes was reviewed and confirmed. History obtained from mother. raa/cs9

Screening:

08:35 **Abuse screen:** dgg

Denies threats or abuse.

Patient fall risk assessment; risks identified; None.

Learning Barriers:

No barriers to teaching and learning identified.

Pedi Fall Risk

None Identified.

Exposure risk/Travel Screening:

None identified. Has not been out of the country.

Assessment:

08:48 **Pain:** level that is acceptable is 0 out of 10 on a pain scale. **General:** Appears well developed, well nourished, well groomed, Behavior is appropriate for age, mobility; ambulates without assistance. **Neuro:** Level of Consciousness is alert, awake. **EENT:** No deficits noted. **Cardiovascular:** Capillary refill < 3 seconds is brisk in bilateral fingers. **Respiratory:** Respiratory effort is even, labored, with nasal flaring, with retractions, Respiratory pattern is regular, symmetrical, tachypnea Airway is patent Breath sounds with wheezes upon exhalation, bilaterally. Parent/caregiver reports the patient having shortness of breath cough that is **Gastrointestinal:** Parent/caregiver reports the patient having normal bowel habits. **Genitourinary:** Parent/caregiver reports the patient having normal urinary habits. **Dermatologic:** Skin is intact, is healthy with good turgor. **Musculoskeletal:** No deficits noted. Age appropriate behavior- Toddler (12 months to 4 yrs); autonomy-separate from parent, appropriate language skills, fears pain, safety concerns. smc

09:25 **General:** **Neuro:** Level of Consciousness is alert, awake. **Respiratory:** Respiratory effort is even, with retractions, Respiratory pattern is symmetrical, tachypnea Breath sounds with wheezes bilaterally. hacking cough noted. oph

10:05 **General:** No retractions noted at this time, wheezing has improved. Dry cough remains. Patient up playing oph

Nurse's Notes Con't

on bed. NAD noted .

12:55 **General:** Patient appears to be sleeping at this time. **Respiratory:** Reassessment: Patient appears in no cph
apparent distress at this time. Patient states symptoms have improved. faint wheezing noted, No retractions,
no nasal flair. .

15:20 **General:** RT to see patient prior to going to the floor, additional breathing treatment per RT. . cph

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Height	Pain	Staff
08:35	143 / 91	174	32	99.7(R)	91% on R/A	16.78 kg / 36 lbs 16 oz	3 ft. 1 in. (93.98 cm)		dgg
09:24		149	34		99%				cph
10:05		146	32		98% on R/A				cph
12:54		135	30		95% on R/A				cph
15:21		130	30		96%				cph

08:35 Body Mass Index 19.00 (16.78 kg, 93.98 cm)

09:24 patient receiving breathing treatment at this time

Vitals:

08:35 Acuity: 2 - Emergent.

Glasgow Coma Score:

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
08:35	spontaneous(4)	oriented(5)	obeys commands(6)		15	dgg

ED Course:

08:34 Patient arrived in ED. ms2
08:34 Patient moved to KIOSK. ms2
08:41 Patient moved to 13. dgg
08:46 Aycock II, Richard, MD is Attending Physician. raa
08:46 Patient/caregiver encouraged to voice any concerns. Side rails up X 1. Bed in low position. Call light in reach. Instructed to call for assist when getting up, verbalized understanding. Patient has correct armband on for positive identification. Adult with patient. Child being held by parent. smc
09:06 Critical Med Co-Sign: Omapred 1.5 tsp po, dosage verified by SUSAN CLARY HOVINGH,RN. sh1
09:13 Hanson, Chenoa, RN is Primary Nurse. cph
09:23 Patient moved to Radiology. jsr
09:23 Chest 2 View *routine* Sent. jsr
09:24 Critical Med Co-Sign: albuterol 0.5 unit dose, dosage verified by SUSAN CLARY HOVINGH,RN. sh1
10:03 Patient moved to 13. pdh
10:44 No apparent distress. Resting quietly. ER nurse to see patient. cph
12:54 No apparent distress. Resting quietly. Appears to be sleeping. ER nurse to see patient. cph
13:25 Craig, Anna, MD is Hospitalizing Provider. raa
13:26 Waiting for Bed Assignment. raa
14:21 Waiting for Bed Assignment. ck3
15:18 Missed attempts: 22 gauge X 1 in left antecubital area, Bleeding controlled, band aid applied, catheter tip intact. cph
15:19 No procedures done that require assistance. Inserted saline lock IV, 22 gauge in left hand. cph

Name: Aaliyah

MRN: 1116206

Account#: K20033856236

Page 2 of 3

*Nurse's Notes Con't***Administered Medications:**

Time	Drug & Dose <i>Dispensable & Quantity</i>	Volume	Route	Rate	Infused Over	Site	Delivery	Staff
09:06	Albuterol 0.5 unit dose		Inhalation					smc
09:23	Follow up: Response: No Adverse Reaction; Tolerated well							cph
09:06	Orapred 1.5 tsp		PO					smc
12:15	Follow up: Response: No Adverse Reaction; Tolerated well							cph
09:24	Albuterol 0.5 unit dose		Inhalation					cph
12:14	Follow up: Response: No Adverse Reaction; Tolerated well							cph
11:54	Albuterol 0.5 unit dose		Inhalation					smc
12:54	Follow up: Response: No Adverse Reaction; Tolerated well							cph

Outcome:

13:26 Decision to Hospitalize by Provider. raa

15:19 Moved to Floor Room # 504, accompanied by tech, family with patient, via wheelchair, with chart, Report cph
called to Valarie RN, using the SBAR communication method. Instructed on admit to floor admission
process Demonstrated understanding of instructions, medications, Prescriptions given; None. No questions
or concerns expressed to me at discharge. **Medication reconciliation form provided. Med Effects:**
Effects of administered medications were addressed. **Oxygen use:** Oxygen use not applicable.

15:50 Electronic medical record closed. cc1

Signatures:

Clinger, Steven, RN	RN	smc	Aycock II, Richard, MD	MD	raa
Hovingh, Sue, RN	RN	sh1	Hinton, Pattie, RT	RT	pdh
Rivers, Jaime, RT	RT	jsr	Hanson, Chenoa, RN	RN	cph
Gardner, Glyn, RN	RN	dgg	Scriptuser, MEDHOST		ms2
Colon, Cindy, RN	RN	cc1	Scott, Christian, Scribe	Scribe	cs9
Kemp, Christine, ED Tech	ED	ck3			
	Tech				

Corrections:

08:50 ~~08:48~~ Respiratory: Respiratory effort is even, labored, with nasal flaring, with retractions, Respiratory
pattern is regular, symmetrical, tachypnea Airway is patent Parent/caregiver reports the patient
having shortness of breath cough that is ~~smc~~ smc

Name: Aaliyah [REDACTED]

MRN: 1116206

Account#: K20033856236

Page 3 of 3

Physician Documentation**Willis Knighton South**

Name: Aaliyah [REDACTED]
 Age: 3 yrs Sex: Female DOB: 10/01/2013
 Arrival Date: 07/15/2017 Time: 08:34
 Bed 13

MRN: 1116206
 Account#: K20033856236
 Private MD:

HPI:

07/15 This 3 yrs old Black/African Am Female presents to ED via Carried with complaints of **Breathing** raa/cs9
 08:51 **Difficulty**.

08:51 The patient presents to the emergency department with cough, wheezing, breathing difficulty. Onset: The symptoms/episode began/occurred and became worse this morning. Associated signs and symptoms: Pertinent positives: cough, shortness of breath, wheezing, Pertinent negatives: congestion, constipation, diarrhea, fever, nasal discharge, seizure, vomiting. Modifying factors: The patient symptoms are alleviated by nothing, the patient symptoms are aggravated by nothing. Treatment prior to arrival: albuterol nebulizer, amoxicillin. The patient has experienced similar episodes in the past. The patient has been recently seen by a physician: in the Willis Knighton emergency department, yesterday, with similar presenting complaints, X-rays were performed, was given a prescription for antibiotics, but the patient's symptoms have worsened. raa/cs9

Historical:

- **Allergies:** SEA FOOD;
- **Home Meds:**
 1. albuterol sulfate 1.25 mg/3 mL Inhl nebu as needed
 2. amoxicillin 250 mg/5 mL PO susr 10 mL every 12 hours
 3. codeine sulfate 15 mg/2.5 mL (2.5 mL) PO soln 2.5 mL every 4 hours as needed
- **PMHx:** Asthma
- **PSHx:** None

Historical:

08:48 Family history: No immediate family members are acutely ill. Immunization history: Childhood immunizations up to date. Social history: The patient lives at home with family the patient is a minor. Code Status: Full code. smc
 08:51 The history from nurses notes was reviewed and confirmed. History obtained from mother. raa/cs9

ROS:

08:51 ROS as in the HPI, and all other systems were reviewed negative, or noncontributory, except as mentioned below. **Eyes:** Negative for injury, redness, swelling, and discharge **ENT:** Negative for injury, congestion, and discharge, **Neck:** Negative for injury, decreased range of motion, and swelling **Cardiovascular:** Negative for edema **Abdomen/GI:** Negative for vomiting, diarrhea, constipation, abdominal distension, anorexia, hematemesis, black/tarry stool **Back:** Negative for injury and deformity **GU:** Negative for injury, bleeding, discharge, and swelling, **MS/Extremity:** Negative for injury, deformity, and decreased range of motion **Skin:** Negative for injury, rash, and discoloration, **Neuro:** Negative for weakness and seizure activity. **Constitutional:** Positive for coughing, shortness of breath, Negative for crying, fever, poor PO intake, vomiting. **Respiratory:** Positive for cough, shortness of breath, wheezing, Negative for hemoptysis. raa/cs9

Exam:

08:51 raa/cs9

Head/Face: Normocephalic, atraumatic.

Eyes: Pupils equal round and reactive to light, extra-ocular motions intact. Lids and lashes normal. Conjunctiva and sclera are non-icteric and not injected. Cornea within normal limits. Periorbital areas with no swelling, redness, or edema.

ENT: Nares patent. No nasal discharge, no septal abnormalities noted. Tympanic membranes are normal and external auditory canals are clear. Oropharynx with no redness, swelling, or masses, exudates, or evidence of obstruction, uvula midline. Mucous membrane

Neck: Trachea midline, no thyromegaly or masses palpated, and no cervical lymphadenopathy. Supple, full range of motion without nuchal rigidity, or vertebral point tenderness. No Meningismus. Lymphatic No abnormal lymphadenopathy noted by palpation in the neck or axilla

Physician Documentation Con't.

Chest/axilla: Normal symmetrical motion. No tenderness. No crepitus. No axillary masses or tenderness.

Abdomen/GI: Soft, non-tender with normal bowel sounds. No distension, tympany or bruits. No guarding, rebound or rigidity. No palpable masses or evidence of tenderness with thorough palpation.

Back: No spinal tenderness. No costovertebral tenderness. Full range of motion.

Skin: Warm and dry with excellent turgor. capillary refill <2 seconds. No cyanosis, pallor, rash or edema.

MS/ Extremity: Pulses equal, no cyanosis. Neurovascular intact. Full, normal range of motion.

Neuro: Awake and alert, GCS 15, oriented to person, place, time, and situation. Cranial nerves II-XII grossly intact. Motor strength 5/5 in all extremities. Sensory grossly intact. Cerebellar exam normal. Normal gait.

Constitutional: The patient appears Blood pressure, pulse, respirations and temperature noted. awake, alert, well developed, well hydrated, well nourished, non-toxic, afebrile.

Cardiovascular: Rhythm is sinus tachycardia. Pulses: equal and symmetrical bilaterally, in the upper extremities, in the lower extremities, no pulse deficits are appreciated, Heart sounds: normal, normal S1 and S2, no murmur, no rub, no gallop, Edema: is not appreciated.

Respiratory: mild respiratory distress is noted, Respirations: asymmetrical chest movement, is not seen, accessory muscle usage, is absent, grunting, is not present, nasal flaring, is not appreciated, intercostal retractions, that is moderate, shallow respirations, are not present, Breath sounds: rales, are not appreciated, rhonchi, are not appreciated, crackles, are not appreciated, wheezing, that is moderate, bronchial sounds, are not appreciated.

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Height	Pain	Staff
08:35	143 / 91	174	32	99.7(R)	91% on R/A	16.78 kg / 36 lbs 16 oz	3 ft. 1 in. (93.98 cm)		dgg
09:24		149	34		99%				cph
10:05		146	32		98% on R/A				cph
12:54		135	30		95% on R/A				cph
15:21		130	30		96%				cph

08:35 Body Mass Index 19.00 (16.78 kg, 93.98 cm)

09:24 patient receiving breathing treatment at this time

dgg

cph

Glasgow Coma Score:

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
08:35	spontaneous(4)	oriented(5)	obeys commands(6)		15	dgg

MDM:

08:56 Patient medically screened.

raa

13:23

raa

Differential diagnosis: bacterial infection, bronchitis, pneumonia URI, viral infection, reactive airway.

Data reviewed: vital signs, nurses notes, radiologic studies, plain films, and as a result, I will admit patient, administer steroids, Orapred.

Data interpreted: Pulse oximetry: normal.

Counseling: I had a detailed discussion with the patient and/or guardian regarding: the historical points, exam findings, and any diagnostic results supporting the discharge/admit diagnosis, lab results, radiology results, the need for further work-up and treatment in the hospital.

Medication response: xopenex.

Response to treatment: the patient's symptoms have mildly improved after treatment.

ED course: MDM- CRITICAL CARE ACTIONS include repeated neb txs, po steroids.

Order	Status	Time	By	For
Albuterol 0.5 unit dose Inhalation every 15 minutes x2	Ordered	07/15/17 08:57	raa	raa

Name: Aaliyah [REDACTED]

MRN: 1116206

Account#: K20033856236

Print Time: 7/16/2017 17:50:42

Page 2 of 4

Physician Documentation Con't.

	Administered 1 of 2	07/15/17 09:06	smc	
	Administered 2 of 2	07/15/17 09:24	cph	
Notes:	Order Method: Electronic			
Drug alert over ride reasons: Clinically indicated				
07/15/17 09:06	Administered 1 of 2: Albuterol 0.5 unit dose Inhalation			smc
07/15/17 09:23	Follow Up: Response: No Adverse Reaction; Tolerated well			cph
07/15/17 09:24	Administered 2 of 2: Albuterol 0.5 unit dose Inhalation			cph
07/15/17 12:14	Follow Up: Response: No Adverse Reaction; Tolerated well			cph
Order	Status	Time	By	For
Orapred 1.5 tsp PO once	Ordered	07/15/17 08:57	raa	raa
	Administered	07/15/17 09:06	smc	
Notes:	Order Method: Electronic			
07/15/17 09:06	Administered: Orapred 1.5 tsp PO			smc
07/15/17 12:15	Follow Up: Response: No Adverse Reaction; Tolerated well			cph
Order	Status	Time	By	For
Chest 2 View *routine*	Ordered	07/15/17 08:57	raa	raa
	Reviewed	07/15/17 10:46	Richard Aycock II	
Notes: Bed Name: 13	Order Method: Electronic			
Interpretation: Per Radiologist's finding(s): XRCXR2VFinal ReportAdmitting Diagnosis: BREATHIUNG DIFFICULTYReason For Exam: Breathing Difficulty Interpretive Location: KBURGINProcedure Date: 07/15/2017 Accession Number: 3704330Procedure: SXR - XR, chest 2 view CPT Code: 71020 IMPRESSION: No acute cardiopulmonary disease. RESULT: Procedure: XR, chest 2 view Clinical Information: Breathing Difficulty Comparison: 7/14/2017 Findings:Heart size and contour are within normal limits. The lungs are clear of infiltrate, mass lesion, or effusion. No significant skeletal abnormality is seen. Electronically Signed by: KOREY PATRICK BURGIN M.D. on Jul 15 2017 9:45A3704330.				
WEIGHT?: (OERDWEIGHT): 16.78				
ER EXAM ROOM/BED: (OERDERRMBD): 13				
Is the patient able to bear weight? (OERDBEARWT):				
Is the patient at risk for falls? (OERDFALLS):				
MODE OF TRANSPORTATION : (OERDTRANS): Stretcher				
O2: (OEADO2): No				
Priority RAD: Stat				
REASON FOR EXAM: (OERDEXAM): Breathing Difficulty				
Order	Status	Time	By	For
Call X-Ray Tech	Ordered	07/15/17 08:57	raa	raa
	Completed	07/15/17 09:00	Steven Clinger	
Notes:	Order Method: Electronic			
Order	Status	Time	By	For
Albuterol 0.5 unit dose Inhalation once	Ordered	07/15/17 11:41	raa	raa
	Administered	07/15/17 11:54	smc	

Name: Aaliyah

MRN: 1116206

Account#: K20033856236

Print Time: 7/16/2017 17:50:42

Page 3 of 4

Physician Documentation Con't.

Notes:	Order Method: Electronic
Drug alert over ride reasons: Clinically indicated	
07/15/17 11:54 Administered: Albuterol 0.5 unit dose Inhalation	smc
07/15/17 12:54 Follow Up: Response: No Adverse Reaction; Tolerated well	cph

Order Signatures:

Aycock II, Richard, MD MD raa

Scribe Statement:

07/15

08:50 Scribed for **Dr. Richard A Aycock II, MD** by Christian Scott, Scribe

raa/cs9

Disposition:

13:23 Electronically signed by: R Aycock MD. I personally performed the services described in this documentation raa as scribed in my presence and it is both accurate and complete.

Disposition:

07/15/17 13:26 Hospitalization ordered by Craig, Anna for Observation. Preliminary diagnosis is acute reactive airway disease .

- Bed requested for Specific Bed.
- Status is Observation.
- Condition is Good.
- Problem is new.
- Symptoms have improved.

cc1

Signatures:

Dispatcher MedHost	EDMS	Clinger, Steven, RN	RN	smc
Aycock II, Richard, MD	MD raa	Hanson, Chenoa, RN	RN	cph
Gardner, Glyn, RN	RN dgg	Colon, Cindy, RN	RN	cc1
Scott, Christian, Scribe	Scribe cs9	Kemp, Christine, ED Tech	ED Tech	ck3

Name: Aaliyah [REDACTED]

MRN: 1116206
Account#: K20033856236
Page 4 of 4

Print Time: 7/16/2017 17:50:42

Generated from 07/15/2017 00:00 to 07/18/2017 23:59

Pt Name:	[REDACTED] L	MRN:	1116206
Pt ID:	0101757329	Acct No:	K20033856236
DOB:	10/01/2013	Age/Sex:	3Y/F
Adm DTime:	07/15/2017	Attn Dr:	Craig, Anna MD
Dsch DTime:	07/16/2017		
Entity:	Willis-Knighton South		
Dx:			

Order #: 1864590
Order Type/Sub Type: Admit/Discharge/Transfer/Admit
Order As Written: Patient status: Observation

Order History

Order Source: CPOE Order
Ordered By: Richard Andre Aycock, MD
Entered By: Richard Andre Aycock, MD on 7/15/2017 1:46:00PM
Order Entered by Richard Andre Aycock, MD on 07/15/2017 13:46
Active by Valarie J Vann, RN on 07/15/2017 16:37
Discontinue by HSF_JS on 07/16/2017 23:01
Reason for Revision: Visit is closed for the patient
Electronically Signed By: Richard Andre Aycock, MD on 7/15/2017 1:46:00PM

Order #: 1865727
Order Type/Sub Type: Admit/Discharge/Transfer/Admit
Order As Written: Attending physician Anna Michelle Craig, MD Complete care turned over to listed Attending. Please contact listed Attending for any changes in patient status or questions related to admission orders and patient care.
Order Source: CPOE Order
Ordered By: Richard Andre Aycock, MD
Entered By: Richard Andre Aycock, MD on 7/15/2017 1:46:00PM
Order Entered by Richard Andre Aycock, MD on 07/15/2017 13:46
Active by Valarie J Vann, RN on 07/15/2017 16:37
Discontinue by HSF_JS on 07/16/2017 23:01
Reason for Revision: Visit is closed for the patient
Electronically Signed By: Richard Andre Aycock, MD on 7/15/2017 1:46:00PM

Order #: 1865728
Order Type/Sub Type: Admit/Discharge/Transfer/Level of Care
Order As Written: Level of care Medical Surgical Unit
Order Source: CPOE Order
Ordered By: Richard Andre Aycock, MD
Entered By: Richard Andre Aycock, MD on 7/15/2017 1:46:00PM
Order Entered by Richard Andre Aycock, MD on 07/15/2017 13:46
Active by Valarie J Vann, RN on 07/15/2017 16:37
Discontinue by HSF_JS on 07/16/2017 23:01
Reason for Revision: Visit is closed for the patient
Electronically Signed By: Richard Andre Aycock, MD on 7/15/2017 1:46:00PM

Generated from 07/15/2017 00:00 to 07/18/2017 23:59

Pt Name: [REDACTED] L
Pt ID: 0101757329
DOB: 10/01/2013
Adm DTime: 07/15/2017
Dsch DTime: 07/16/2017
Entity: Willis-Knighton South
Dx:

MRN: 1116206
Acct No: K20033856236
Age/Sex: 3Y/F
Attn Dr: Craig, Anna MD

Order #: 1865732
Order Type/Sub Type: Dietary/Oral
Order As Written: Diet: Regular

Order History

Order Source: CPOE Order
Ordered By: Richard Andre Aycock, MD
Entered By: Richard Andre Aycock, MD on 7/15/2017 1:46:00PM
Order Entered by Richard Andre Aycock, MD on 07/15/2017 13:46
Active by Valarie J Vann, RN on 07/15/2017 16:37
Discontinue by HSF_JS on 07/16/2017 23:01
Reason for Revision: Visit is closed for the patient
Electronically Signed By: Richard Andre Aycock, MD on 7/15/2017 1:46:00PM

Order #: 1865726
Order Type/Sub Type: General/Clinical Factors
Order As Written: Diagnosis: acute reactive airway disease

Order History

Order Source: CPOE Order
Ordered By: Richard Andre Aycock, MD
Entered By: Richard Andre Aycock, MD on 7/15/2017 1:46:00PM
Order Entered by Richard Andre Aycock, MD on 07/15/2017 13:46
Active by Valarie J Vann, RN on 07/15/2017 16:37
Discontinue by HSF_JS on 07/16/2017 23:01
Reason for Revision: Visit is closed for the patient
Electronically Signed By: Richard Andre Aycock, MD on 7/15/2017 1:46:00PM

Order #: 1865733 Soarian Order #: 1439577
Order Type/Sub Type: Medication/IV/
Order As Written: SODIUM CHLORIDE 0.9% (FS) (1000 ML bag) Intravenous @25mL/Hour Over 40H for 3 Days

Order History

Order Source: CPOE Order
Ordered By: Richard Andre Aycock, MD
Entered By: Richard Andre Aycock, MD on 7/15/2017 1:46:00PM
Order Entered by Richard Andre Aycock, MD on 07/15/2017 13:46
Validated by SRX on 07/15/2017 14:04
Validated by Valarie J Vann, RN on 07/15/2017 16:37
Suspend by MedSys on 07/16/2017 16:15
Discontinue by HSF_JS on 07/16/2017 23:03
Electronically Signed By: Richard Andre Aycock, MD on 7/15/2017 1:46:00PM

Pt. Name [REDACTED] L

MRN: 1116206
Page 2 of 5

Entity: Willis-Knighton South

Adm Date: 07/15/2017

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Orders Report

ORE 0149 DSCH.rpt version v1.00

Generated By: Workflow

Generated On: 17-Jul-17 16:15

Generated from 07/15/2017 00:00 to 07/18/2017 23:59

Pt Name: [REDACTED] L
Pt ID: 0101757329
DOB: 10/01/2013
Adm DTime: 07/15/2017
Dschr DTime: 07/16/2017
Entity: Willis-Knighton South
Dx:

MRN: 1116206
Acct No: K20033856236
Age/Sex: 3Y/F
Attn Dr: Craig, Anna MD

Order #: 1865730
Order Type/Sub Type: Nursing/Activity
Order As Written: Bedrest with bathroom privileges

Order History

Order Source: CPOE Order
Ordered By: Richard Andre Aycock, MD
Entered By: Richard Andre Aycock, MD on 7/15/2017 1:46:00PM
Order Entered by Richard Andre Aycock, MD on 07/15/2017 13:46
Active by Valerie J Vann, RN on 07/15/2017 16:37
Complete by Valerie J Vann, RN on 07/15/2017 17:53
Electronically Signed By: Richard Andre Aycock, MD on 7/15/2017 1:46:00PM

Order #: 1865731
Order Type/Sub Type: Respiratory/Respiratory General
Order As Written: Oxygen Protocol

Order History

Order Source: CPOE Order
Ordered By: Richard Andre Aycock, MD
Entered By: Richard Andre Aycock, MD on 7/15/2017 1:46:00PM
Order Entered by Richard Andre Aycock, MD on 07/15/2017 13:46
Active by Valerie D Mitchell, RT on 07/15/2017 14:44
Discontinue by Valerie D Mitchell, RT on 07/15/2017 15:16
Discontinue by Valerie D Mitchell, RT on 07/15/2017 15:16
Reason for Revision: dc'd per protocol 7/15
Electronically Signed By: Richard Andre Aycock, MD on 7/15/2017 1:46:00PM

Order #: 1865729
Order Type/Sub Type: Vital Signs/
Order As Written: Vital signs per Vital Signs policy

Order History

Order Source: CPOE Order
Ordered By: Richard Andre Aycock, MD
Entered By: Richard Andre Aycock, MD on 7/15/2017 1:46:00PM
Order Entered by Richard Andre Aycock, MD on 07/15/2017 13:46
Active by Valerie J Vann, RN on 07/15/2017 16:37
Discontinue by HSF_JS on 07/16/2017 23:01
Reason for Revision: Visit is closed for the patient
Electronically Signed By: Richard Andre Aycock, MD on 7/15/2017 1:46:00PM

Pt. Name: [REDACTED] L

MRN: 1116206

Orders Report

Entity: Willis-Knighton South

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Generated from 07/15/2017 00:00 to 07/18/2017 23:59

Pt Name: [REDACTED] L
Pt ID: 0101757329
DOB: 10/01/2013
Adm DTime: 07/15/2017
Dsck DTime: 07/16/2017
Entity: Willis-Knighton South
Dx:

MRN: 1116206
Acct No: K20033856236
Age/Sex: 3Y/F
Atn Dr: Craig, Anna MD

Order #: 1864584 Soarian Order #: 1437891
Order Type/Sub Type: Medication/IV/
Order As Written: METHYLPREDNISOLONE (SOLU-MEDROL) 17 MG = 0.425 ML Intravenous VIAL Q12H for 31 Days

Order History

Order Source: CPOE Order
Ordered By: Richard Andre Aycock, MD
Entered By: Richard Andre Aycock, MD on 7/15/2017 1:47:00PM
Order Entered by Richard Andre Aycock, MD on 07/15/2017 13:47
Validated by SRX on 07/15/2017 14:04
In progress by Valerie J Vann, RN on 07/15/2017 16:37
Suspend by MedSys on 07/16/2017 16:15
Discontinue by HSF_JS on 07/16/2017 23:03
Electronically Signed By: Richard Andre Aycock, MD on 7/15/2017 1:47:00PM

Order #: 1865756 Soarian Order #: 1443568
Order Type/Sub Type: Medication/IV/Nebulized
Order As Written: ALBUTEROL 0.083% (PROVENTIL 0.083%) 2.5 MG = 3 ML Nebulization SOLN 4XDAY RT for 31 Days

Order History

Order Source: CPOE Order
Ordered By: Richard Andre Aycock, MD
Entered By: Richard Andre Aycock, MD on 7/15/2017 1:48:00PM
Order Entered by Richard Andre Aycock, MD on 07/15/2017 13:48
Validated by SRX on 07/15/2017 14:04
Validated by Valerie D Mitchell, RT on 07/15/2017 14:44
Discontinue by SRX on 07/15/2017 17:34
Discontinue by Valerie J Vann, RN on 07/15/2017 17:53
Electronically Signed By: Richard Andre Aycock, MD on 7/15/2017 1:48:00PM

Pt. Name: [REDACTED] L

MRN: 1116206

Orders Report

Entity: Willis-Knighton South

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Generated from 07/15/2017 00:00 to 07/18/2017 23:59

Pt Name: [REDACTED] L
Pt ID: 0101757329
DOB: 10/01/2013
Adm DTime: 07/15/2017
Dsch DTime: 07/16/2017
Entity: Willis-Knighton South
Dx:

MRN: 1116206
Acct No: K20033856236
Age/Sex: 3Y/F
Attn Dr: Craig, Anna MD

Order #: 1867866
Order Type/Sub Type: Consult/General Consult
Order As Written: Social Services consult Other (specify) Mother would like a new home nebulizer. Patient's does not work

Order History
Order Source: Patient Care Order
Ordered By: Anna Michelle Craig, MD
Entered By: Jennifer R Lee, RN on 7/15/2017 4:31:00PM

Order Entered by Jennifer R Lee, RN on 07/15/2017 16:31

Active by Valerie J Vann, RN on 07/15/2017 16:37

Discontinue by HSF_JS on 07/16/2017 23:01

Reason for Revision: Visit is closed for the patient

Electronically Signed By:

Electronically Signed by:
CRAIG, ANNA MICHELLE
M.D. on 22-Jul-2017
16:17:08 -0500

Order #: 1868120 Soarian Order #: 1439533
Order Type/Sub Type: Medication/IV/Nebulized
Order As Written: ALBUTEROL 0.083% (PROVENTIL 0.083%) 2.5 MG = 3 ML Nebulization SOLN Q4H RT for 31 Days

Order History
Order Source:
Ordered By: Anna Michelle Craig, MD
Entered By: SRX on 7/15/2017 5:34:00PM

Validated by SRX on 07/15/2017 17:34

In progress by Valerie J Vann, RN on 07/15/2017 17:53

In progress by Haley B Rodrigues, RT on 07/15/2017 19:02

In progress by Brittany M Denton, RT on 07/16/2017 06:57

Suspend by MedSys on 07/16/2017 16:15

Discontinue by HSF_JS on 07/16/2017 23:03

Electronically Signed By:

Electronically Signed by:
CRAIG, ANNA MICHELLE
M.D. on 22-Jul-2017
16:17:08 -0500

Order #: 1879396
Order Type/Sub Type: Admit/Discharge/Transfer/Discharge
Order As Written: Discharge to: (specify) Home

Order History
Order Source: CPOE Order
Ordered By: Sharon Nhu Tran, MD
Entered By: Sharon Nhu Tran, MD on 7/16/2017 3:49:00PM

Order Entered by Sharon Nhu Tran, MD on 07/16/2017 15:49

Complete by Valerie J Vann, RN on 07/16/2017 15:59

Complete by Valerie J Vann, RN on 07/16/2017 16:12

Electronically Signed By: Sharon Nhu Tran, MD on 7/16/2017 3:49:00PM

Pt Name: [REDACTED] L

MRN: 1116206

Orders Report

Entity: Willis-Knighton South

Page 5 of 5

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Allergies

☒ Known allergies (including food) Codine / Shellfish

Height: _____ Weight: 15.8 Kg

Prohibited Abbreviation:

Please Use:

Prohibited Abbreviation

Please Use:

Never write a decimal point (X mg)

Always use a zero before a decimal point (0.x mg)

Committee Approved Blank Order Form – Must be Hand Written

PO 193

Revised 07/05/2017

Committee Approved 07/05/2017

Page 1 of 1



10/01/13 3Y,09M.
Craig, Anna M. M.D. S5504
K20033856236 07/15/13

Willis-Knighton South
2510 Bert Kouns Industrial Loop
Shreveport, LA 71118

Patient Name: [REDACTED]
Adm No: K20033856236
DOB: 10/01/2013
Age: 3Y F
Corp ID: 000001116206

MRN: 1116206
Location: ER Patient - ERS
Ord No: 90016
Hospital: WKS

Ordering Dr: RICHARD ANDRE AYCOCK II

CC:

Final Report

Admitting Diagnosis: BREATHING DIFFICULTY
Reason For Exam: Breathing Difficulty
Procedure Date: 07/15/2017
Procedure: SXR - XR, chest 2 view

Interpretive Location: KBURGIN
Accession Number: 3704330
CPT Code: 71020

IMPRESSION: No acute cardiopulmonary disease.

RESULT:

Procedure: XR, chest 2 view

Clinical Information: Breathing Difficulty

Comparison: 7/14/2017

Findings:

Heart size and contour are within normal limits. The lungs are clear of infiltrate, mass lesion, or effusion. No significant skeletal abnormality is seen.

Electronically Signed by: KOREY PATRICK BURGIN M.D. on Jul 15 2017 9:45A

Techs: Jaime S Rivers
Additional Staff:

Read by: KOREY PATRICK BURGIN M.D. on Jul 15 2017 9:45A
Electronically Signed by: KOREY PATRICK BURGIN M.D. on Jul 15 2017 9:45A

Printed: Jul 15 2017 9:49AM

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07/18/2017 00:04

DISCHARGE MEDICATION ADMINISTRATION RECORD
Willis-Knighton Health System

PAGE: 1 OF 3

PATIENT NO: K20033856236
MED REC NO: 1116206
SITE: WKSHNAME: [REDACTED] L
AGE: 3Y DOB: 10/01/2013 SEX: F
ATN DOCTOR: CRAIG, ANNA MICHELLE MDDSCH LOC: S5E1/S5504A
DSCH DATE: 07/16/2017
ADMIT DATE: 07/15/2017

*** MEDICATIONS CURRENT AT THE TIME OF DISCHARGE ***

*** SCHEDULED MEDICATIONS ***

ORD# 4
ALBUTEROL 0.083% 2.5 MG = 3 ML
(PROVENTIL 0.083%)
Q4H RT NEBULIZED EVERY FOUR HOURS RT
START: 07/15/17 17:31 STOP: 08/15/17 17:30
Nrs Verified By: VMITCH
07/15/17 17:46 ADMIN VMITCH at: 07/15/17 17:46
07/15/17 19:18 ADMIN HRODRI at: 07/15/17 19:18
07/15/17 22:20 ADMIN HRODRI at: 07/15/17 22:20
07/16/17 02:09 ADMIN HRODRI at: 07/16/17 02:09
07/16/17 07:29 ADMIN BDENTO at: 07/16/17 07:29
07/16/17 11:19 ADMIN BDENTO at: 07/16/17 11:19

ORD# 4 (REVISED)
ALBUTEROL 0.083% 2.5 MG = 3 ML
(PROVENTIL 0.083%)
Q4H RT NEBULIZED EVERY FOUR HOURS RT
START: 07/15/17 17:31 STOP: 07/16/17 23:01
Nrs Verified By: VMITCH
**** ORDER DISCONTINUED ****

ORD# 1 (REVISED)
METHYLPREDNISOLONE 17 MG = 0.425 ML
(SOLU-MEDROL)
Q12H IV EVERY 12 HOURS
START: 07/15/17 14:00 STOP: 08/15/17 02:00
Nrs Verified By: VVANNO
07/15/17 14:00 ADMIN VVANNO at: 07/15/17 16:32
07/16/17 02:00 ADMIN JGRIFF at: 07/16/17 02:29
07/16/17 14:00 ADMIN VVANNO at: 07/16/17 15:18

ORD# 1 (REVISED)
METHYLPREDNISOLONE 17 MG = 0.425 ML
(SOLU-MEDROL)
Q12H IV EVERY 12 HOURS
START: 07/15/17 14:00 STOP: 07/16/17 23:01
Nrs Verified By: VVANNO
**** ORDER DISCONTINUED ****

*** IVS CURRENT AT THE TIME OF DISCHARGE ***

*** SCHEDULED IVS ***

ORD# 2 UB: A
PLAIN PLAIN IV
SODIUM CHLORIDE 0.9% (FS) 1000 ml
IV CONTINUOUS CONTINUOUS
RATE: 25 ml/hr RUN-IN: 40 hrs
START: 07/15/17 13:39 STOP: 07/18/17 13:38
Nrs Verified By: HRODRI
**** NO OCCURRENCES CHARTED ****

ORD# 2 (REVISED) UB: A
PLAIN PLAIN IV
SODIUM CHLORIDE 0.9% (FS) 1000 ml
IV CONTINUOUS CONTINUOUS
RATE: 25 ml/hr RUN-IN: 40 hrs
START: 07/15/17 13:39 STOP: 07/16/17 23:01
Nrs Verified By: HRODRI
**** ORDER DISCONTINUED ****

<PERMANENT CHART COPY>

07/18/2017 00:04

DISCHARGE MEDICATION ADMINISTRATION RECORD
Willis-Knighton Health System

PAGE: 2 OF 3

PATIENT NO: K20033856236
MED REC NO: 1116206
SITE: WKSH

NAME: [REDACTED] L
AGE: 3Y DOB: 10/01/2013 SEX: F
ATN DOCTOR: CRAIG, ANNA MICHELLE MD

DSCH LOC: S5E1/S5504A
DSCH DATE: 07/16/2017
ADMIT DATE: 07/15/2017

*** ORDERS DISCONTINUED AT THE TIME OF DISCHARGE ***

*** MEDICATIONS ***

ORD# 3
ALBUTEROL 0.083% 2.5 MG = 3 ML
(PROVENTIL 0.083%)
4XDAY RT NEBULIZED FOUR TIMES A DAY RT
START: 07/15/17 13:39 STOP: 08/15/17 13:38
Nrs Verified By:
**** NO OCCURRENCES CHARTED ****

ORD# 3 (REVISED)
ALBUTEROL 0.083% 2.5 MG = 3 ML
(PROVENTIL 0.083%)
4XDAY RT NEBULIZED FOUR TIMES A DAY RT
START: 07/15/17 13:39 STOP: 07/15/17 17:32
Nrs Verified By: HRODRI
**** ORDER DISCONTINUED ****

<PERMANENT CHART COPY>

07/18/2017 00:04

DISCHARGE MEDICATION ADMINISTRATION RECORD
Willis-Knighton Health System

PAGE: 3 OF 3

PATIENT NO: K20033856236
MED REC NO: 1116206
SITE: WKSH

NAME: [REDACTED] L
AGE: 3Y DOB: 10/01/2013 SEX: F
ATN DOCTOR: CRAIG, ANNA MICHELLE MD

DSCH LOC: S5E1/S5504A
DSCH DATE: 07/16/2017
ADMIT DATE: 07/15/2017

*** NURSE IDENTIFICATION ***

BDENTO Denton, Brittany RT
HRODRI Rodrigues, Haley RT
JGRIFF Griffith, Jennifer RN
VMITCH Mitchell, Valerie RT
VVANNO Vann, Valarie RN

<PERMANENT CHART COPY>

ACLS/PALS Results for 15.8 (34.8 lb)

e 1 of 4

Dosing Calculators - Emergency DrugsSelect Dosing Type: ☒ Pediatric ☐ AdultPatient Weight: 15.8 ☒ kg ☐ lb

Results: [Sat Jul 15 21:19:05 GMT 2017]

Pediatric Emergency Drug Dosing Calculator

This calculator is intended to calculate dosing for pediatric patients aged 29 days or older; it is not intended for dosing of neonates. As with all MICROMEDEX products, please use caution and exercise your clinical discretion and professional judgment when utilizing this calculator.

Sat Jul 15 21:19:05 GMT 2017

Patient Name:

Entered Values: Dosing Type: Pediatric Patient Weight: 15.8 kg (34.8 lb)

Recommendations according to AHA guidelines ACLS/PALS resuscitation.

*Attention - Institutionally dispensed drug concentrations may vary.

Drug	Route	Dose	Delivery
Adenosine			
Initial: 0.1 mg/kg/dose MAX: 6 mg/dose Repeat: 0.2 mg/kg/dose MAX: 12 mg/dose	Rapid IV/IO Push	1.58 mg/dose (0.53 mL/dose of 3 mg/mL conc) MAX: 6 mg/dose Repeat: 3.16 mg/dose (1.05 mL/dose of 3 mg/mL conc) MAX: 12 mg/dose	Immediately follow drug administration with at least 5 mL normal saline.
Amiodarone			
5 mg/kg/dose MAX: 300 mg/dose May repeat dose twice up to MAX: 15 mg/kg	IV/IO	79 mg/dose (1.58 mL/dose of a 50 mg/mL conc) for pulseless VT/VF, give as rapid bolus; for perfusing tachycardias, infuse over 20 to 60 minutes MAX: 300 mg/dose May repeat dose twice up to MAX: 237 mg	Dilute to 1 to 6 mg/mL in D5W.

ACLS/PALS results for 15.8 (74.8 lb)

2 of 4

Drug	Route	Dose	Delivery
Atropine			
IV: 0.02 mg/kg/dose MAX: 0.5 mg/dose May repeat once	IV/IO	0.32 mg/dose (3.16 mL/dose of 0.1 mg/mL conc) MAX: 0.5 mg May repeat once	
ET: 0.04 to 0.06 mg/kg/dose MAX: 0.5 mg/dose May repeat once	ET	0.5 mg/dose (0.5 mL/dose of 1 mg/mL conc) Dose based on 0.04 mg/kg/dose MAX: 0.5 mg May repeat once	Dilute in NS to a volume of 5 mL and follow instillation by 5 positive pressure ventilations via ambu-bag.
Calcium chloride 10%			
20 mg/kg/dose MAX: 2 g/dose	Slow IV/IO	316 mg/dose (3.2 mL/dose of 100 mg/mL conc) MAX: 2 g/dose	Administer slowly.
Cardioversion			
0.5 to 1 joule/kg May Repeat 2 joules/kg	Electrical	7.9 joules Dose based on: 0.5 joules/kg May Repeat 32 joules	
Defibrillation			
Initial shock: 2 joules/kg Second shock: 4 joules/kg	Electrical	Initial shock: 31.6 joules Second shock: 63.2 joules	Subsequent shocks of 4 joules/kg or more up to a MAX: 10 joules/kg or adult dose, whichever is less.
Dextrose			
0.5 to 1 g/kg MAX: 25 g	IV/IO	7.9 g/dose (32 mL/dose of D25W) Dose based on: 0.5 g/kg MAX: 25 g	Infants and children: Use D25W. May dilute D50W 1:1 with sterile water to make D25W prior to administration. Adolescents: Use D50W.
DOBUTamine hydrochloride			
2 to 20 mcg/kg/min	IV/IO	Starting dose: 79 mcg/min (4.7 mL/hr of a 1000 mcg/mL conc) Dose based on: 5 mcg/kg/min	Mix 20 mL from a 12.5 mg/mL vial in 250 mL D5W for a 1000 mcg/mL solution.

ACLS/PALS results for 15.8 kg (4.8 lb)

Page 3 of 4

Drug	Route	Dose	Delivery
DOPamine			
2 to 20 mcg/kg/min	IV/IO	Starting dose: 79 mcg/min (3 mL/hr of a 1600 mcg/mL conc) Dose based on: 5 mcg/kg/min	Mix 10 mL from a 40 mg/mL vial in 250 mL D5W for a 1600 mcg/mL solution.
EPINEPHrine			
IV: 0.01 mg/kg MAX: 1 mg/dose May Repeat every 3 to 5 minutes	IV/IO	0.16 mg/dose (1.6 mL/dose of a 0.1 mg/mL conc) MAX: 1 mg/dose May repeat every 3 to 5 minutes	
ET: 0.1 mg/kg MAX: 2.5 mg/dose May repeat every 3 to 5 minutes	ET	1.6 mg/dose (1.6 mL/dose of a 1 mg/mL conc) MAX: 2.5 mg/dose May repeat every 3 to 5 minutes	Dilute in NS to a volume of 5 mL and follow instillation by 5 positive pressure ventilation via ambu-bag.
EPINEPHrine: Infusion			
0.1 to 1 mcg/kg/min	Infusion	Starting Dose: 1.58 mcg/min (1.9 mL/hr of a 50 mcg/mL conc) Dose based on 0.1 mcg/kg/min	Mix 12.5 mL of 1 mg/mL vial in 250 mL D5W for a 50 mcg/mL solution.
Lidocaine			
IV: 1 mg/kg/dose MAX: 100 mg Repeat bolus if infusion not started within 15 minutes of initial bolus.	IV/IO	16 mg/dose (1.6 mL/dose of 10 mg/mL conc) MAX: 100 mg Repeat bolus if infusion not started within 15 minutes of initial bolus.	
ET: 2 to 3 mg/kg/dose	ET	32 mg/dose (3.2 mL/dose of 10 mg/mL conc) Dose based on 2 mg/kg/dose	Dilute in NS to a volume of 5 mL and follow instillation by 5 positive pressure ventilation via ambu-bag.
Infusion: 20 to 50 mcg/kg/min	Infusion	316 mcg/min (7.9 mL/hr of a 2400 mcg/mL conc) Dose based on 20 mcg/kg/min	Mix 30 mL from a 20 mg/mL vial in 250 mL D5W for a 2400 mcg/mL solution.
Magnesium sulfate			
25 to 50 mg/kg/dose MAX: 2 g/dose	IV/IO	395 mg/dose (0.8 mL/dose of 500 mg/mL conc) over 10 to 20 minutes, faster in torsades de pointes MAX: 2 g/dose Dose based on 25 mg/kg/dose	Dilute to a MAX of 200 mg/mL.

ACLS/PALS Results for 15.8 (34.8 lb)

Page 4 of 4

Drug	Route	Dose	Delivery
Naloxone For Full Reversal			
IV: younger than 5 years old or 20 kg or less: 0.1 mg/kg/dose MAX: 2 mg/dose 5 years and older or more than 20 kg: 2 mg/dose	IV/IO/ET	For Full Reversal: younger than 5 years old or 20 kg or less: 1.58 mg/dose (1.6 mL/dose of 1 mg/mL conc) MAX: 2 mg/dose 5 years and older or more than 20 kg: 2 mg/dose	For ET administration: May require 2 to 3 times IV dose. Dilute ET dose in NS to a volume of 5 mL and follow instillation by 5 positive pressure ventilations via ambu-bag. Use lower doses to reverse respiratory depression associated with therapeutic opioid use (1 to 5 mcg/kg titrate to effect).
Procainamide			
15 mg/kg/dose	IV/IO	237 mg/dose (2.37 mL/dose of 100 mg/mL conc) infuse over 30 to 60 minutes	Dilute in NS to a conc of 20 mg/mL. Monitor ECG and blood pressure. Use caution when administering with other drugs that prolong QA.
Sodium bicarbonate			
1 mEq/kg/dose	IV/IO	16 mEq/dose (16 mL/dose of 1 mEq/mL conc)	After adequate ventilation.

RUN DATE: 6/17/17 Ellis Knighton Ath *ADMISSIO
RUN TIME: 0846 INTERDISCIPLINARY ALLERGY SOURCE DOCUMENT
RUN USER: MORANC.AM

PAGE 1

Name: [REDACTED] L DOB: 10/01/13 Age: 3Y 09M
Rm/Bd: Serv/Locn: ERS Status: ER Sex: F
Unit#: K000629604 Account#: K20033856236 EPI#: 000000001116206

Last Update/
Acknowledgement:

Interdisciplinary Assessment (Free Text), historical data:

Allergy1-Med/Contact: NKDA	11/04/16 - 2201
Allergy2-Med/Contact: NKDA	11/04/16 - 2201
Food Allergies-Intol: NKFA	11/04/16 - 2201
Latex Allergy (Y/N): N	11/04/16 - 2201

Pharmacy Allergy List (Coded Allergies), historical data:
(Duplicate names represent coding within (3) categories:
Ingredient, Generic and Class allergy codes.)

11/06/16

NO KNOWN DRUG ALLERGIES, NO KNOWN FOOD ALLERGIES, NO KNOWN LATEX ALLERGY

Interdisciplinary Allergy Source Document is a Permanent Part of
the Patient's Medical Record

Willis Knighton Respiratory

Account: K20033856236	Physician Name:	Admit Date: 7/15/2017 1:59:00 PM
First Name: [REDACTED]	MRN: 1116206	Discharge Date:
Last Name: [REDACTED]	Date of Birth: 10/01/2013	Charting Category: MEDTX
Charting Template: Treatment Note	Charting Date: 7/16/2017 11:19:00 AM	Charting ID: 1000930968

Heart Rate: 92 beats per minute
Respiratory Rate: 24 breaths per minute
All Lung Fields: Clear
Work of Breathing: No use of accessory muscles noted.
PAIN: No pain communicated or visualized by respiratory therapy at this time.

Interventions:
MEDICATION THERAPY: Small volume nebulizer treatment given via face mask for pediatric patient, with Albuterol 0.083% (2.5 mg/3 mL)
Treatment delivered via oxygen.

The patient had no adverse effects.

Post Therapy Assessment:
Heart Rate: 95 beats per minute
Respiratory Rate: 26 breaths per minute
Breath Sounds:
All Lung Fields: Clear
Work of Breathing: No use of accessory muscles noted.
Cough/Suction: Patient had no cough at this time.

Education:
No education was provided at this time.

Electronically Signed By: Brittany Denton, RRT on 07/16/2017 at 11:24

Willis Knighton Respiratory

Account: K20033856236	Physician Name:	Admit Date: 7/15/2017 1:59:00 PM
First Name: [REDACTED]	MRN: 1116206	Discharge Date:
Last Name: [REDACTED]	Date of Birth: 10/01/2013	Charting Category: MEDTX
Charting Template: Treatment Note	Charting Date: 7/16/2017 7:29:00 AM	Charting ID: 1000930654

Heart Rate: 120 beats per minute
Respiratory Rate: 22 breaths per minute
All Lung Fields: Clear
Work of Breathing: No use of accessory muscles noted.
PAIN: No pain communicated or visualized by respiratory therapy at this time.

Interventions:
MEDICATION THERAPY: Small volume nebulizer treatment given via face mask for pediatric patient, with Albuterol 0.083% (2.5 mg/3 mL)
Treatment delivered via oxygen.

The patient had no adverse effects.

Post Therapy Assessment:
Heart Rate: 136 beats per minute
Respiratory Rate: 26 breaths per minute
Breath Sounds:
All Lung Fields: Clear
Work of Breathing: No use of accessory muscles noted.
Cough/Suction: Patient had no cough at this time.

Education:
No education was provided at this time.

Electronically Signed By: Brittany Denton, RRT on 07/16/2017 at 07:32

Willis Knighton Respiratory

Account: K20033856236	Physician Name:	Admit Date: 7/15/2017 1:59:00 PM
First Name: [REDACTED]	MRN: 1116206	Discharge Date:
Last Name: [REDACTED]	Date of Birth: 10/01/2013	Charting Category: MEDTX
Charting Template: Treatment Note	Charting Date: 7/16/2017 2:09:00 AM	Charting ID: 1000930420

Heart Rate: 134 beats per minute
Respiratory Rate: 32 breaths per minute
All Lung Fields: Clear
Work of Breathing: No use of accessory muscles noted.
PAIN: No pain communicated or visualized by respiratory therapy at this time.

Interventions:
MEDICATION THERAPY: Small volume nebulizer treatment given via face mask for pediatric patient, with Albuterol 0.083% (2.5 mg/3 mL)
Treatment delivered via oxygen.

The patient had no adverse effects.

Post Therapy Assessment:
Heart Rate: 123 beats per minute
Respiratory Rate: 28 breaths per minute
Breath Sounds:
All Lung Fields: Clear
Work of Breathing: No use of accessory muscles noted.
Cough/Suction: Patient had a strong non-productive cough.

Education:
No education was provided at this time.

Electronically Signed By: Haley Rodrigues, RRT on 07/16/2017 at 02:11

Willis Knighton Respiratory

Account: K20033856236	Physician Name:	Admit Date: 7/15/2017 1:59:00 PM
First Name: [REDACTED]	MRN: 1116206	Discharge Date:
Last Name: [REDACTED]	Date of Birth: 10/01/2013	Charting Category: MEDTX
Charting Template: Treatment Note	Charting Date: 7/15/2017 10:20:00 PM	Charting ID: 1000930232

Heart Rate: 134 beats per minute
Respiratory Rate: 24 breaths per minute
All Lung Fields: Clear
Work of Breathing: No use of accessory muscles noted.
PAIN: No pain communicated or visualized by respiratory therapy at this time.

Interventions:
MEDICATION THERAPY: Small volume nebulizer treatment given via face mask for pediatric patient, with Albuterol 0.083% (2.5 mg/3 mL)
Treatment delivered via oxygen.

The patient had no adverse effects.

Post Therapy Assessment:
Heart Rate: 131 beats per minute
Respiratory Rate: 24 breaths per minute
Breath Sounds:
All Lung Fields: Clear
Work of Breathing: No use of accessory muscles noted.
Cough/Suction: Patient had no cough at this time.

Education:
No education was provided at this time.

Electronically Signed By: Haley Rodrigues, RRT on 07/15/2017 at 22:22

Willis Knighton Respiratory

Account: K20033856236	Physician Name:	Admit Date: 7/15/2017 1:59:00 PM
First Name: [REDACTED]	MRN: 1116206	Discharge Date:
Last Name: [REDACTED]	Date of Birth: 10/01/2013	Charting Category: MEDTX
Charting Template: Treatment Note	Charting Date: 7/15/2017 7:18:00 PM	Charting ID: 1000930044

Heart Rate: 137 beats per minute
Respiratory Rate: 36 breaths per minute
All Lung Fields: Clear
Work of Breathing: No use of accessory muscles noted.
PAIN: No pain communicated or visualized by respiratory therapy at this time.

Interventions:
MEDICATION THERAPY: Small volume nebulizer treatment given via face mask for pediatric patient, with Albuterol 0.083% (2.5 mg/3 mL).
Treatment delivered via oxygen.

The patient had no adverse effects.

Post Therapy Assessment:
Heart Rate: 135 beats per minute
Respiratory Rate: 30 breaths per minute
Breath Sounds:
All Lung Fields: Clear
Work of Breathing: No use of accessory muscles noted.
Cough/Suction: Patient had no cough at this time.

Education:
No education was provided at this time.

Electronically Signed By: Haley Rodrigues, RRT on 07/15/2017 at 19:19

Willis Knighton Respiratory

Account: K20033856236	Physician Name:	Admit Date: 7/15/2017 1:59:00 PM
First Name: [REDACTED]	MRN: 1116206	Discharge Date:
Last Name: [REDACTED]	Date of Birth: 10/01/2013	Charting Category: MEDTX
Charting Template: Treatment Note	Charting Date: 7/15/2017 3:00:00 PM	Charting ID: 1000929808

Heart Rate: 144 beats per minute
Respiratory Rate: 28 breaths per minute
All Lung Fields: Expiratory wheezes
Work of Breathing: No use of accessory muscles noted.
PAIN: No pain communicated or visualized by respiratory therapy at this time.

Interventions:
MEDICATION THERAPY: Small volume nebulizer treatment started via face mask for pediatric patient, with Albuterol 0.083% (2.5 mg/3 mL)
Treatment delivered via oxygen.

The patient had no adverse effects.

Post Therapy Assessment:
Heart Rate: 152 beats per minute
Respiratory Rate: 28 breaths per minute
Breath Sounds:
All Lung Fields: Expiratory wheezes
Work of Breathing: No use of accessory muscles noted.
Cough/Suction: Patient had no cough at this time.

Education:
Informal: Indications, possible side effects, expected outcomes of therapy and/or current status were explained.

Electronically Signed By: Valerie Mitchell, RRT on 07/15/2017 at 15:12

Willis Knighton Respiratory

Account: K20033856236	Physician Name:	Admit Date: 7/15/2017 1:59:00 PM
First Name: [REDACTED]	MRN: 1116206	Discharge Date:
Last Name: [REDACTED]	Date of Birth: 10/01/2013	Charting Category: MEDGAS-SAT
Charting Template: Oxygen Therapy-Oximetry Note	Charting Date: 7/15/2017 3:00:00 PM	Charting ID: 1000929807

Pediatric Oxygen Protocol

Room Air SpO2 = 97 %. Oxygen not set up per protocol.

Electronically Signed By: Valerie Mitchell, RRT on 07/15/2017 at 15:11

Plan Of Care Report

Generated from 07/15/2017 00:00 to 07/18/2017 23:59

Pt Name: HENDERSON, AALIYAH L MRN: 1116206
 Pt ID: 0101757329 Acct No: K20033856236
 DOB: 10/01/2013 Age/Sex: 3Y/F
 Adm DTime: 07/15/2017 08:34 Attn Dr: Craig, Anna MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Allrg: codeine, Fish Containing Products, Fish containing products

Plan of Care

Last Reviewed By: Valarie J Vann, RN
 Last Reviewed Date: 07/16/2017 07:08

Standard Name	Date Assigned	Assigned By	Stop Date	Reason
POC Mental Status - Impaired	07/15/2017 16:28	Lee, Jennifer RN		
POC Falls - Risk of	07/15/2017 16:28	Lee, Jennifer RN		
POC Breathing Pattern - Ineffect	07/15/2017 16:28	Lee, Jennifer RN		

Problems associated to Selected Visit

Problem Name	Rank	Date Assigned	Date Closed	Assigned By	Closed By	Status
Problem Details	Value	Problem Details	Value	Problem Details	Value	
Activity Intolerance		07/15/2017 16:27		Jennifer R Lee, RN		Resolved
Status:						
Gas Exchange - Impaired		07/15/2017 16:27		Jennifer R Lee, RN		Resolved
Status:						
Breathing Pattern - Ineffective		07/15/2017 16:27		Jennifer R Lee, RN		Resolved
Status:						
Falls - Risk of		07/15/2017 16:27		Jennifer R Lee, RN		Resolved
Comment:		Status:				
Mobility - Impaired		07/15/2017 16:27		Jennifer R Lee, RN		Resolved
Status:						
Tissue Perfusion - Cardiopulmonary, Altered		07/15/2017 16:27		Jennifer R Lee, RN		Resolved
Status:						
Self-care Deficit - Toileting		07/15/2017 16:27		Jennifer R Lee, RN		Resolved
Status:						
Self-care Deficit - Feeding		07/15/2017 16:27		Jennifer R Lee, RN		Resolved
Status:						
Infection - risk of		07/15/2017 16:27		Jennifer R Lee, RN		Resolved
Associated With: Peripheral IV		Status:				
Self-care Deficit - Dressing and Grooming		07/15/2017 16:27		Jennifer R Lee, RN		Resolved
Status:						
Self-care Deficit - Bathing		07/15/2017 16:27		Jennifer R Lee, RN		Resolved
Status:						
Mental Status - Impaired		07/15/2017 16:27		Jennifer R Lee, RN		Resolved
Status:						

Pt Name: [REDACTED] L
 Rm/ Bed:

MRN: 1116206
 Page 1 of 2

Plan Of Care Report
 ORE_0146_DSCH_NBR_v1.rpt v1.00
 Printed By: Workflow
 Printed On: 17-Jul-17 16:15

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Plan Of Care Report

Generated from 07/15/2017 00:00 to 07/18/2017 23:59

Pt Name: [REDACTED] L MRN: 1116206
 Pt ID: 0101757329 Acct No: K20033856236
 DOB: 10/01/2013 Age/Sex: 3Y/F
 Adm DTime: 07/15/2017 08:34 Atn Dr: Craig, Anna MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Alrg: codeine, Fish Containing Products, Fish containing products

Expected Outcomes

Expected Outcome Display Name		Status	Act. Outcome		Charted By
Comment		Target Completion Date	Status (Last)		Charted Date
Outcome Details	Value	Outcome Details	Value	Outcome Details	Value
Cognitive status restored to baselin		Erroneous		Met	Jennifer R Lee, RN 07/15/2017 16:28
Absence of falls		Active 07/17/2017 12:00		Met	Valarie J Vann, RN 07/16/2017 15:26
Absence of physical injury		Active 07/17/2017 12:00		Met	Valarie J Vann, RN 07/16/2017 15:26
Effective breathing pattern		Active 07/17/2017 12:00		Progressing	Valarie J Vann, RN 07/16/2017 15:26

Pt Name: [REDACTED] L
 Rm/ Bed:

MRN: 1116206
 Page 2 of 2

Plan Of Care Report
 ORE_0146_DSCH_NBR_v1.rpt v1.00

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 Printed On: 17-Jul-17 16:15

Assessment Report

Generated from 07/15/2017 00:00 to 07/18/2017 23:59

Pt Name: [REDACTED] L MRN: 1116206
 Pt ID: 0101757329 Acct No: K20033856236
 DOB: 10/01/2013 Age/Sex: 3Y/F
 Adm DTime: 07/15/2017 08:34 Atn Dr: Craig, Anna MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Alrg: codeine, Fish Containing Products, Fish containing products

Admission Assessment

Assessment Sts Complete Collected DTime 07/15/2017 16:07
 Collected By Jennifer R Lee, RN

Admission Assessment

Stated reason for visit	ER Yesterday congested cold, ear infection 7/14. Today wheezing 7/15	Admit from	ED
Mode of arrival	Wheelchair	Accompanied by	Parent
Source of info	Parent	Preferred name	Jennifer Alexander
Would you like a family member / representative notified of your	No	Emergency contact	mother
Readmit within 30 days	Denies	Organ donor	No
Participates in Clinical Trial	No	Current treatments	Respiratory
Comments	Albuterol Q 4 hours as needed shortness of breath/wheezing	Communication barriers	Cognitive, Emotional
Highest education level	Less than 5th grade	Current grade	Pre-school
Language preference for medical communication	English	Communication barrier	None
Comment	Patient has autism	No spiritual/cultural issues that may affect care or education	Yes
Do you have an Advance Directive?	No	Do you want an Advance Directive?	No
WKHS Patient Guide provided	Yes	Healthcare Power of Attorney	No
Healthcare Power of Attorney on file with WKHS	No	Oriented to	Yes
Person oriented	Parent	Admit from other	Home

Belongings / Equipment

No belongings	Yes	No medical equipment or assistive devices	Yes
---------------	-----	---	-----

Birth History

Birth weight	1/9 lbs, oz	Mother received prenatal care	Yes
Mother's prenatal care	yes	Problems at birth	Mother had preeclampsia. Born at 27 weeks. NICU -100 days

Past Med/Surg Hx

Pt Name: [REDACTED] L
 Rm/ Bed:

MRN: 1116206
 Page 1 of 5

Assessment Report
 ORE_0010_DSCH_NBR_V1.rpt v1.00
 Printed By :Workflow
 Printed On: 17-Jul-17 16:15

Assessment Report

Generated from 07/15/2017 00:00 to 07/18/2017 23:59

Pt Name: [REDACTED] L MRN: 1116206
 Pt ID: 0101757329 Acct No: K20033856236
 DOB: 10/01/2013 Age/Sex: 3Y/F
 Adm DTime: 07/15/2017 08:34 Atn Dr: Craig, Anna MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Alerg: codeine, Fish Containing Products, Fish containing products

Admission Assessment

Assessment Sts	Complete	Collected DTime	07/15/2017 16:07
Collected By	Jennifer R Lee, RN		
Past Med/Surg Hx			
Neurological medical history	Other (specify)	Neurological comments	Autism
Respiratory medical history	Asthma	No history of cancer	Yes
Infectious Disease History			
Have you/close contact travel outside continental US last 30days	No	Have you come in contact with any person with confirmed Ebola	No
Have you or close contact come in contact with anyone with ZIKA	No		
Health Screening			
Hazardous material exposure	Denies	No change in appetite, unintentional weight loss, vomiting or	Yes
Unintentional weight loss lately	No	Poor weight gain over the last few months	No
Eating / feeding less in the last few weeks	No	Obviously underweight (BMI less than 5%)	No
Body Mass Index	13.88	Date of Last BM	07/13/2017
Exercise regularly	Denies	Sleep aids/meds	No
Weight	34/13.329 lbs, oz	Height	3.5 ft, in
Diarrhea (2 or more days in the past week)	No		
Developmental Assessment			
3 Years	Able to throw ball overhand		
Immunization Screening			
Contraindications	Patient under 18 years of age, Vaccine not required (April - August)	Contraindications	Patient under 65 years of age
Immunization comments	UTD	Hepatitis A vaccine yes/no	Yes
Hepatitis B vaccine yes/no	Yes	Tetanus vaccine in last 10 years	Yes
Family Health History			
Father	Not known	Mother	Hypertension, Obesity
Brother	Not known		

Pt Name: [REDACTED] L
 Rm/ Bed:

MRN: 1116206
 Page 2 of 5

Assessment Report
 ORE_0010_DSCH_NBR_V1.rpt.v1.00
 Printed By :Workflow
 Printed On: 17-Jul-17 16:15

Assessment Report

Generated from 07/15/2017 00:00 to 07/18/2017 23:59

Pt Name: [REDACTED] L MRN: 1116206
 Pt ID: 0101757329 Acct No: K20033856236
 DOB: 10/01/2013 Age/Sex: 3Y/F
 Adm DTime: 07/15/2017 08:34 Attn Dr: Craig, Anna MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Allrg: codeine, Fish Containing Products, Fish containing products

Admission Assessment

Assessment Sts Complete Collected DTime 07/15/2017 16:07
 Collected By Jennifer R Lee, RN

Psychosocial History

Lives with	Parent	Home environment	Home
Caffeine use	Denies	Alcohol use	Denies
Illicit drug use	Denies	Smoking status	Never smoker
Smokeless tobacco use	Denies	Second hand smoke exposure	Denies
Smoking cessation program information	No	Have you had thoughts of harming yourself in the past week?	Denies
Does your home environment cause you fear, pain, or injury?	Denies	Have you recently felt abused, taken advantage of, or neglected	Denies
Spiritual resources needed	No	Are you or your family experiencing grief or difficulty coping	Denies
Is grieving for fetal/newborn loss?	Denies		

ADL Assessment

Activity	Partial assist	Activity tolerance	Fair
Hygiene	Partial assist	Dressing	Partial assist
Grooming	Partial assist	Toileting	Partial assist
Eating	Partial assist	Med administration	Complete assist
Stairs	Independent	Driving	Not applicable

Vital Signs

Height	3.5 ft.in	How Obtained	Measured
Weight	34/13.329 lbs,oz	How Obtained	Measured
Body Mass Index	13.88	Ideal Body Weight, female	10.16
Ideal Body Weight, male	20.16		

Pain / Sedation Assessment

Total score	5	Face	Frequent to constant quivering chin, clenched jaw
Legs	Uneasy, restless, tense	Activity	Squirming, shifting back and forth, tense
Cry	Moans or whimpers, occasional complaint	Consolability	Content, relaxed

HEENT Assessment

Head	WDL	Eyes	WDL
------	-----	------	-----

Pt Name: [REDACTED] L MRN: 1116206
 Rm/ Bed: Page 3 of 5

Assessment Report

ORE_0010_DSCH_NBR_V1.rpt v1.00

Printed By :Workflow

Printed On: 17-Jul-17 16:15

Assessment Report

Generated from 07/15/2017 00:00 to 07/18/2017 23:59

Pt Name: [REDACTED] L MRN: 1116206
 Pt ID: 0101757329 Acct No: K20033856236
 DOB: 10/01/2013 Age/Sex: 3Y/F
 Adm DTime: 07/15/2017 08:34 Atn Dr: Craig, Anna MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Allrg: codeine, Fish Containing Products, Fish containing products

Admission Assessment

Assessment Sts	Complete	Collected DTime	07/15/2017 16:07
Collected By	Jennifer R Lee, RN		
HEENT Assessment			
Ears	WDL	Nose	WDL
Mouth	WDL	Throat	WDL
Respiratory Assessment			
Oxygen	WDL except	Respiratory	WDL except
Retracting / Bulging	Mild retracting	Cough	Non - productive
Breath sounds within defined limits	WDL except	LUL	Coarse rales
LLL	Coarse rales	RUL	Coarse rales
RML	Coarse rales	RLL	Coarse rales
Cardiovascular Assessment			
Cardiovascular	WDL	Peripheral circulation	WDL
Gastrointestinal Assessment			
Gastrointestinal	WDL		
Genitourinary Assessment			
Genitourinary	WDL	Urinary catheter present on admission	Not applicable
Indwelling Urinary Catheter present on admission	No	External genitalia	Deferred
Musculoskeletal Assessment			
Musculoskeletal	WDL	Bones and Joints	WDL
Neurological Assessment			
Eye opening	Spontaneous	Motor response	Moves spontaneously or purposefully
Verbal response	Cries but consolable, inappropriate interactions	GCS Total Score	14
Neurological	WDL except	Oriented to	Unable to assess
Oriented to person, place and time	No	Motor function	WDL
Integumentary Assessment			
Integumentary	WDL		
Braden Skin Risk Assessment			
Mobility: Ability to change and control body position	No Limitations	Activity: Degree of physical activity	Walks Occasionally

Pt Name: [REDACTED] L

MRN: 1116206

Assessment Report

Rm/ Bed:

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ORE_0010_DSCH_NBR_V1.rpt v1.00

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Pt Name: [REDACTED] L MRN: 1116206
Pt ID: 0101757329 Acct No: K20033856236
DOB: 10/01/2013 Age/Sex: 3Y/F
Adm DTime: 07/15/2017 08:34 Atn Dr: Craig, Anna MD
Nurs Sta: S 5 East 1 Rm & Bed:
Dx:
A1rg: codeine, Fish Containing Products, Fish containing products

Admission Assessment

Assessment Sts Complete Collected DTime 07/15/2017 16:07
Collected By Jennifer R Lee, RN

Braden Skin Risk Assessment

Sensory Perception:	Slightly Limited	Moisture	Occasionally Moist
Friction and shear	No Apparent Problem	Nutrition: Usual food intake pattern	Adequate
Tissue perfusion and oxygenation	Adequate	Modified Braden Score	23

Fall Risk Assessment

Age	3 to less than 7 years old	Gender	Female
Diagnosis	Neurological diagnosis	Cognitive Impairment	Forgets limitations
Environmental Factors	Placed in bed	Response to Surgery/Sedation/Anesthesia	More than 48 hours / None
Medication Usage	Other medications / None	Humpty Dumpty score	14
Fall risk level	High risk		

Education - Multidisciplinary

Nursing education topic	Activities of daily living	Description 1	Admission Assessment
Barriers to learning	None	Person educated	Parent
Teaching method	Discussion, Handouts	Evaluation method	Verbal
Follow-up	No follow-up needed		

Discharge Planning

Equipment comments Possibly needs new nebulizer

Clinical Note:

Pt Name: [REDACTED] L

MRN: 1116206

Assessment Report

Rm/ Bed:

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Assessment Report

Generated from 07/15/2017 00:00 to 07/18/2017 23:59

Pt Name: [REDACTED] L MRN: 1116206
Pt ID: 0101757329 Acct No: K20033856236
DOB: 10/01/2013 Age/Sex: 3Y/F
Adm DTime: 07/15/2017 08:34 Attn Dr: Craig, Anna MD
Nurs Sta: S 5 East 1 Rm & Bed:
Dx:
Alerg: codeine, Fish Containing Products, Fish containing products

CM Notes

Assessment Sts Complete Collected DTime 07/16/2017 17:12
Collected By Kimberly T McCray

CM Notes

Care Management Note SS C/S-MOTHER WOULD LIKE A NEW HOME NEBULIZER. PATIENT'S MACHINE DOES NOT WORK. DISCUSSION HELD WITH MOTHER AS HHN WAS ORDERED THRU ALLEGIANCE MEDICAL SUPPLY IN 2015, THEREFORE, INSURANCE WILL NOT COVER ANOTHER ONE UNTIL AFTER (5) YEARS. ADVISED MOTHER TO GET A RX FOR RESP MEDS AND TAKE IT TO MEDIC PHARMACY AS THEY WILL PROVIDE A NEBULIZER MACHINE AT NO COST. MOTHER EXPLAINED PT'S RX HAS ALREADY BEEN FILLED. SUGGESTED TO MOTHER TO SEE IF SHE CAN HAVE THAT PARTICULAR RX TRANSFERRED TO MEDIC PHARMACY IN ORDER TO GET A FREE MACHINE. MOTHER VERBALIZED THAT SHE WILL WORK ON GETTING IT DONE. NO FURTHER CONCERNS AT THIS TIME.

Clinical Note:

Pt Name: [REDACTED] L
Rm/ Bed:

MRN: 1116206
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Assessment Report

ORE_0010_DSCH_NBR_V1.rpt v1.00

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 Pt ID: 0101757329 Acct No: K20033856236
 DOB: 10/01/2013 Age/Sex: 3Y/F
 Adm DTime: 07/15/2017 08:34 Atn Dr: Craig, Anna MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Alrg: codeine, Fish Containing Products, Fish containing products

Discharge Assessment

Assessment Sts Complete Collected DTime 07/16/2017 15:48
 Collected By Valarie J Vann, RN

Discharge Assessment

Temperature	98.8 F	Pulse	120
Respirations	22	O2 Saturation (%)	99
Date of last bowel movement	07/16/2017	Contraindications	Patient under 65 years of age
Contraindications	Patient under 18 years of age	Discharge instructions	Reviewed discharge instructions with patient / significant other, Patient unaccompanied, Patient / Significant other verbalized understanding of discharge instructions, Patient / Significant other received written instructions

Discharge Follow-up and Equipment

With Referral 1 PCP, at UH Follow-up In 1-2 days

Integumentary Assessment

Integumentary WDL

Education - Multidisciplinary

Nursing education topic	Asthma	Barriers to learning	None
Person educated	Family	Teaching method	Discussion
Understanding	Good	Evaluation Method	Verbal
Follow-up	No Follow-up Needed	Smoking cessation program information	No

Physician D/C Instructions

Diet	Pediatric	Notify Physician For	Fever or chills, Temperature over 100.5 lasting more than 8 hours, Shortness of breath, If symptoms worsen contact your health care provider or call 911
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Clinical Note:

Discharge Planning

Assessment Sts Complete Collected DTime 07/15/2017 19:20
 Collected By Jennifer A Griffith, RN

Discharge Planning

Equipment comments Possibly needs new nebulizer

Pt Name: [REDACTED] L

MRN: 1116206

Assessment Report

Rm/ Bed:

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Assessment Report

Generated from 07/15/2017 00:00 to 07/18/2017 23:59

Pt Name:	██████████ L	MRN:	1116206
Pt ID:	0101757329	Acct No:	K20033856236
DOB:	10/01/2013	Age/Sex:	3Y/F
Adm DTime:	07/15/2017 08:34	Atn Dr:	Craig, Anna MD
Nurs Sta:	S 5 East 1	Rm & Bed:	
Dx:			
Alrg:	codeine, Fish Containing Products, Fish containing products		

Clinical Note:

Pt Name: ██████████ L
Rm/ Bed:

MRN: 1116206
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Assessment Report
ORE_0010_DSCH_NBR_V1.rpt v1.00
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Assessment Report

Generated from 07/15/2017 00:00 to 07/18/2017 23:59

Pt Name: [REDACTED] L MRN: 1116206
 Pt ID: 0101757329 Acct No: K20033856236
 DOB: 10/01/2013 Age/Sex: 3Y/F
 Adm DTime: 07/15/2017 08:34 Atn Dr: Craig, Anna MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Alrg: codeine, Fish Containing Products, Fish containing products

Intake and Output

	07/16/17 15:20	07/16/17 05:44	07/15/17 18:21
Collected By	Valarie J Vann, RN	Jennifer A Griffith, RN	Valarie J Vann, RN
Clinical Note			
Status	Complete	Complete	Complete
Oral	820 ml	240 ml	500 ml
IV fluid #1	237.2 ml	285.7 ml	60 ml

Peripheral IV Assessment

Assessment Sts	Complete	Collected DTime	07/16/2017 15:54
Collected By	Valarie J Vann, RN		
<u>Peripheral IV Assessment</u>			
Date / Time Discontinued, site 1	07/16/2017 15:55	Catheter intact IV 1	Yes
Description, site 1	NO REDNESS, SWELLING OR DRAINAGE NOTED TO SITE, SITE COVERED WITH BANDAID		
Clinical Note:			

Peripheral IV Assessment

Assessment Sts	Complete	Collected DTime	07/16/2017 14:32
Collected By	Valarie J Vann, RN		
<u>Peripheral IV Assessment</u>			
IV 1	Present on admission, inserted at a WKHS acute care facility	Date/Time Inserted, site 1	07/15/2017 15:00
Site IV 1	Hand, right	Size IV 1	20G
IV site condition IV 1	Patent, no redness, tenderness, leakage or edema	Dressing condition IV 1	Clean, dry, intact
Clinical Note:			

Peripheral IV Assessment

Assessment Sts	Complete	Collected DTime	07/16/2017 12:32
Collected By	Valarie J Vann, RN		
<u>Peripheral IV Assessment</u>			
IV 1	Present on admission, inserted at a WKHS acute care	facility	

Pt Name: [REDACTED] L

MRN: 1116206

Assessment Report

Rm/ Bed:

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Assessment Report

Generated from 07/15/2017 00:00 to 07/18/2017 23:59

Pt Name: [REDACTED] L MRN: 1116206
Pt ID: 0101757329 Acct No: K20033856236
DOB: 10/01/2013 Age/Sex: 3Y/F
Adm DTime: 07/15/2017 08:34 Atn Dr: Craig, Anna MD
Nurs Sta: S 5 East 1 Rm & Bed:
Dx:
Alrg: codeine, Fish Containing Products, Fish containing products

Peripheral IV Assessment

Assessment Sts Complete Collected DTime 07/16/2017 12:32
Collected By Valarie J Vann, RN

Peripheral IV Assessment

Date/Time Inserted, site 1	07/15/2017 15:00	Site IV 1	Hand, right
Size IV 1	20G	IV site condition IV 1	Patent, no redness, tenderness, leakage or edema
Dressing condition IV 1	Clean, dry, intact		

Clinical Note:

Peripheral IV Assessment

Assessment Sts Complete Collected DTime 07/16/2017 09:45
Collected By Valarie J Vann, RN

Peripheral IV Assessment

IV 1	Present on admission, inserted at a WKHS acute care facility	Date/Time Inserted, site 1	07/15/2017 15:00
Site IV 1	Hand, right	Size IV 1	20G
IV site condition IV 1	Patent, no redness, tenderness, leakage or edema	Dressing condition IV 1	Clean, dry, intact

Clinical Note:

Peripheral IV Assessment

Assessment Sts Complete Collected DTime 07/16/2017 07:05
Collected By Valarie J Vann, RN

Peripheral IV Assessment

IV 1	Present on admission, inserted at a WKHS acute care facility	Date/Time Inserted, site 1	07/15/2017 15:00
Site IV 1	Hand, right	Size IV 1	20G
IV site condition IV 1	Patent, no redness, tenderness, leakage or edema	Dressing condition IV 1	Clean, dry, intact

Clinical Note:

Peripheral IV Assessment

Assessment Sts Complete Collected DTime 07/16/2017 06:32
Collected By Jennifer A Griffith, RN

Peripheral IV Assessment

IV 1	Present on admission, inserted at a WKHS acute care facility	Date/Time Inserted, site 1	07/15/2017 15:00
Site IV 1	Hand, right	Size IV 1	20G

Pt Name: [REDACTED] L

MRN: 1116206

Rm/ Bed:

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Assessment Report

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Printed On: 17-Jul-17 16:15

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Pt Name: [REDACTED] L MRN: 1116206
Pt ID: 0101757329 Acct No: K20033856236
DOB: 10/01/2013 Age/Sex: 3Y/F
Adm DTime: 07/15/2017 08:34 Atn Dr: Craig, Anna MD
Nurs Sta: S 5 East 1 Rm & Bed:
Dx:
Alrg: codeine, Fish Containing Products, Fish containing products

Peripheral IV Assessment

Assessment Sts Complete Collected DTime 07/16/2017 06:32
Collected By Jennifer A Griffith, RN

Peripheral IV Assessment

IV site condition IV 1 Patent, no redness, tenderness, leakage or edema Dressing condition IV 1 Clean, dry, intact

Clinical Note:

Peripheral IV Assessment

Assessment Sts Complete Collected DTime 07/16/2017 04:32
Collected By Jennifer A Griffith, RN

Peripheral IV Assessment

IV 1 Present on admission, inserted at a WKHS acute care facility Date/Time Inserted, site 1 07/15/2017 15:00
Site IV 1 Hand, right Size IV 1 20G
IV site condition IV 1 Patent, no redness, tenderness, leakage or edema Dressing condition IV 1 Clean, dry, intact

Clinical Note:

Peripheral IV Assessment

Assessment Sts Complete Collected DTime 07/16/2017 02:32
Collected By Jennifer A Griffith, RN

Peripheral IV Assessment

IV 1 Present on admission, inserted at a WKHS acute care facility Date/Time Inserted, site 1 07/15/2017 15:00
Site IV 1 Hand, right Size IV 1 20G
IV site condition IV 1 Patent, no redness, tenderness, leakage or edema Dressing condition IV 1 Clean, dry, intact

Clinical Note:

Peripheral IV Assessment

Assessment Sts Complete Collected DTime 07/16/2017 00:32
Collected By Jennifer A Griffith, RN

Peripheral IV Assessment

IV 1 Present on admission, inserted at a WKHS acute care facility Date/Time Inserted, site 1 07/15/2017 15:00
Site IV 1 Hand, right Size IV 1 20G
IV site condition IV 1 Patent, no redness, tenderness, leakage or edema Dressing condition IV 1 Clean, dry, intact

Pt Name: [REDACTED] L

MRN: 1116206

Assessment Report

Rm/ Bed:

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Pt Name: [REDACTED] L MRN: 1116206
 Pt ID: 0101757329 Acct No: K20033856236
 DOB: 10/01/2013 Age/Sex: 3Y/F
 Adm DTime: 07/15/2017 08:34 Attn Dr: Craig, Anna MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Alrg: codeine, Fish Containing Products, Fish containing products

Clinical Note:

Peripheral IV Assessment

Assessment Sts Complete Collected DTime 07/15/2017 22:32
 Collected By Jennifer A Griffith, RN

Peripheral IV Assessment

IV 1	Present on admission, inserted at a WKHS acute care facility	Date/Time Inserted, site 1	07/15/2017 15:00
Site IV 1	Hand, right	Size IV 1	20G
IV site condition IV 1	Patent, no redness, tenderness, leakage or edema	Dressing condition IV 1	Clean, dry, intact

Clinical Note:

Peripheral IV Assessment

Assessment Sts Complete Collected DTime 07/15/2017 20:32
 Collected By Jennifer A Griffith, RN

Peripheral IV Assessment

IV 1	Present on admission, inserted at a WKHS acute care facility	Date/Time Inserted, site 1	07/15/2017 15:00
Site IV 1	Hand, right	Size IV 1	20G
IV site condition IV 1	Patent, no redness, tenderness, leakage or edema	Dressing condition IV 1	Clean, dry, intact

Clinical Note:

Peripheral IV Assessment

Assessment Sts Complete Collected DTime 07/15/2017 19:20
 Collected By Jennifer A Griffith, RN

Peripheral IV Assessment

IV 1	Present on admission, inserted at a WKHS acute care facility	Date/Time Inserted, site 1	07/15/2017 15:00
Site IV 1	Hand, right	Size IV 1	20G
IV site condition IV 1	Patent, no redness, tenderness, leakage or edema	Dressing condition IV 1	Clean, dry, intact

Clinical Note:

Peripheral IV Assessment

Assessment Sts Complete Collected DTime 07/15/2017 17:52
 Collected By Valerie J Vann, RN

Peripheral IV Assessment

IV 1	Present on admission, inserted at a WKHS acute care
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Pt Name: [REDACTED] L
 Rm/ Bed:

MRN: 1116206
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Assessment Report

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Pt Name: [REDACTED] L MRN: 1116206
 Pt ID: 0101757329 Acct No: K20033856236
 DOB: 10/01/2013 Age/Sex: 3Y/F
 Adm DTime: 07/15/2017 08:34 Atn Dr: Craig, Anna MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Allrg: codeine, Fish Containing Products, Fish containing products

Peripheral IV Assessment

Assessment Sts Complete Collected DTime 07/15/2017 17:52
 Collected By Valarie J Vann, RN

Peripheral IV Assessment

facility	Date/Time Inserted, site 1	07/15/2017 15:00
Site IV 1 Hand, right	Size IV 1	20G
IV site condition IV 1 Patent, no redness, tenderness, leakage or edema	Dressing condition IV 1	Clean, dry, intact

Clinical Note:

Peripheral IV Assessment

Assessment Sts Complete Collected DTime 07/15/2017 16:31
 Collected By Valarie J Vann, RN

Peripheral IV Assessment

IV 1 Present on admission, inserted at a WKHS acute care facility	Date/Time Inserted, site 1	07/15/2017 15:00
Site IV 1 Hand, right	Size IV 1	20G
IV site condition IV 1 Patent, no redness, tenderness, leakage or edema	Dressing condition IV 1	Clean, dry, intact

Clinical Note:

Reassessment

Assessment Sts Complete Collected DTime 07/16/2017 07:06
 Collected By Valarie J Vann, RN

Reassessment

Temperature 98.1 F	Temperature Site	Tympanic
Pulse 122	Pulse site	Cardiac monitor
Respirations 24	O2 Saturation (%)	95
Height 3.5 ft, in	How Obtained	Measured
Weight 34/13.329 lbs, oz	How Obtained	Measured
Body Mass Index 13.88	Ideal Body Weight, female	10.16
Ideal Body Weight, male -1.81		

Patient Location

Primary location In their primary assigned location

Pain / Sedation Assessment

Pasero Opioid-Induced Sedation Scale (POSS) 1 = Awake and alert	Total score	0
Face No particular expression or smile	Legs	Normal position or relaxed

Pt Name: [REDACTED] L

MRN: 1116206

Assessment Report

Rm/ Bed:

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ORE_0010_DSCH_NBR.rpt v1.00

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Generated from 07/15/2017 00:00 to 07/18/2017 23:59

Pt Name:	██████████ L	MRN:	1116206
Pt ID:	0101757329	Acct No:	K20033856236
DOB:	10/01/2013	Age/Sex:	3Y/F
Adm DTime:	07/15/2017 08:34	Atn Dr:	Craig, Anna MD
Nurs Sta:	S 5 East 1	Rm & Bed:	
Dx:			
Allrg:	codeine, Fish Containing Products, Fish containing products		

Reassessment

Assessment Sts	Complete	Collected DTime	07/16/2017 07:06
Collected By	Valarie J Vann, RN		
<u>Pain / Sedation Assessment</u>			
Activity	Lying quietly, normal position, moves easily	Cry	No cry
Consolability	Content, relaxed		
<u>HEENT Assessment</u>			
Head	WDL	Eyes	WDL
Ears	WDL	Nose	WDL
Mouth	WDL	Throat	WDL
<u>Respiratory Assessment</u>			
Oxygen	WDL except	O2 Saturation (%)	95
Respiratory	WDL except	Accessory muscle use	Yes
Retracting / Bulging	Mild retracting	Cough	Non - productive
Breath sounds within defined limits	WDL except	LUL	Coarse rales
LLL	Coarse rales, Wheezes, expiratory	RUL	Coarse rales
RML	Coarse rales, Wheezes, expiratory	RLL	Coarse rales, Wheezes, expiratory
<u>Cardiovascular Assessment</u>			
Cardiovascular	WDL	Peripheral circulation	WDL
<u>Gastrointestinal Assessment</u>			
Gastrointestinal	WDL		
<u>Genitourinary Assessment</u>			
Genitourinary	WDL	Urinary catheter present on admission	Not applicable
Indwelling Urinary Catheter present on admission	No	External genitalia	Deferred
<u>Musculoskeletal Assessment</u>			
Musculoskeletal	WDL	Bones and Joints	WDL
<u>Neurological Assessment</u>			
Eye opening	Spontaneous	Motor response	Moves spontaneously or purposefully
Verbal response	Smiles, oriented to sounds, follows objects, interacts	GCS Total Score	15
Neurological	WDL except	Oriented to	Person

Pt Name: ██████████ L

MRN: 1116206

Assessment Report

Rm/ Bed:

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 DOB: 10/01/2013 Age/Sex: 3Y/F
 Adm DTime: 07/15/2017 08:34 Attn Dr: Craig, Anna MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Allrg: codeine, Fish Containing Products, Fish containing products

Reassessment

Assessment Sts Complete Collected DTime 07/16/2017 07:06
 Collected By Valarie J Vann, RN

Neurological Assessment

Oriented to person, place and time No Behavior Irritable
 Motor function WDL

Integumentary Assessment

Integumentary WDL

Fall Risk Assessment

Age 3 to less than 7 years old Gender Female
 Diagnosis Psych / Behavioral disorders Cognitive Impairment Forgets limitations
 Environmental Factors Placed in bed Response to Surgery/Sedation/Anesthesia More than 48 hours / None
 Medication Usage Other medications / None Humpty Dumpty score 12
 Fall risk level High risk

Clinical Note:

Reassessment

Assessment Sts Complete Collected DTime 07/15/2017 19:20
 Collected By Jennifer A Griffith, RN

Reassessment

Temperature 99.2 F Temperature Site Temporal
 Pulse 158 Pulse site Cardiac monitor
 Respirations 28 O2 Saturation (%) 99
 Height 3.5 ft.in How Obtained Measured
 Weight 34/13.329 lbs,oz How Obtained Measured
 Body Mass Index 13.88 Ideal Body Weight, female 10.16
 Ideal Body Weight, male -1.81

Pain / Sedation Assessment

Total score 3 Face No particular expression or smile
 Legs Uneasy, restless, tense Activity Squirming, shifting back and forth, tense
 Cry Moans or whimpers, occasional complaint Consolability Content, relaxed

HEENT Assessment

Head WDL Eyes WDL
 Ears WDL Nose WDL

Pt Name: [REDACTED] L
 Rm/ Bed:

MRN: 1116206
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Assessment Report

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 Adm DTime: 07/15/2017 08:34 Atn Dr: Craig, Anna MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Alerg: codeine, Fish Containing Products, Fish containing products

Reassessment

Assessment Sts	Complete	Collected DTime	07/15/2017 19:20
Collected By	Jennifer A Griffith, RN		
HEENT Assessment			
Mouth	WDL	Throat	WDL
Respiratory Assessment			
Oxygen	WDL except	O2 Saturation (%)	99
Respiratory	WDL except	Accessory muscle use	Yes
Retracting / Bulging	Mild retracting	Cough	Non - productive
Breath sounds within defined limits	WDL except	LUL	Coarse rales
LLL	Coarse rales, Wheezes, expiratory	RUL	Coarse rales
RML	Coarse rales, Wheezes, expiratory	RLL	Coarse rales, Wheezes, expiratory
Cardiovascular Assessment			
Cardiovascular	WDL	Peripheral circulation	WDL
Gastrointestinal Assessment			
Gastrointestinal	WDL		
Genitourinary Assessment			
Genitourinary	WDL	Urinary catheter present on admission	Not applicable
Indwelling Urinary Catheter present on admission	No	External genitalia	Deferred
Musculoskeletal Assessment			
Musculoskeletal	WDL	Bones and Joints	WDL
Neurological Assessment			
Neurological	WDL except	Oriented to	Person
Oriented to person, place and time	No	Behavior	Irritable
Motor function	WDL		
Integumentary Assessment			
Integumentary	WDL		
Braden Skin Risk Assessment			
Moisture	Occasionally Moist		
Fall Risk Assessment			
Age	3 to less than 7 years old	Gender	Female

Pt Name: [REDACTED] L

MRN: 1116206

Assessment Report

Rm/ Bed:

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Assessment Report

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Pt Name: [REDACTED] L MRN: 1116206
 Pt ID: 0101757329 Acct No: K20033856236
 DOB: 10/01/2013 Age/Sex: 3Y/F
 Adm DTime: 07/15/2017 08:34 Attn Dr: Craig, Anna MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Allrg: codeine, Fish Containing Products, Fish containing products

Reassessment

Assessment Sts Complete Collected DTime 07/15/2017 19:20
 Collected By Jennifer A Griffith, RN

Fall Risk Assessment

Diagnosis	Psych / Behavioral disorders	Cognitive Impairment	Forgets limitations
Environmental Factors	Placed in bed	Response to Surgery/Sedation/Anesthesia	More than 48 hours / None
Medication Usage	Other medications / None	Humpty Dumpty score	12
Fall risk level	High risk	Interventions	Close observation, Environmental safety management (personal items within arm's reach, pathways clear and nonskid footwear provided if applicable), Intentional rounding

Education - Multidisciplinary

Nursing education topic	Infusion Therapy	Description 1	call nurse at onset of any signs of pain at iv site; swelling, redness also
Person educated	Family	Barriers to learning	None
Readiness to Learn	Receptive	Teaching method	Discussion
Understanding	Good	Evaluation Method	Verbal
Follow-up	Content		

Additional Education

Nursing education topic 2	Safety	Description 2	bed in lowest position, side rails up, call light in reach, parent/grandparent at bedside
Person educated	Family	Barriers to learning	None
Readiness to learn	Receptive	Teaching Method	Discussion
Understanding	Good	Evaluation method	Verbal
Follow-up	Content		

Clinical Note:

Pt Name: [REDACTED] L

MRN: 1116206

Assessment Report

Rm/ Bed:

Page 9 of 9

ORE_0010_DSCH_NBR.rpt v1.00

Printed By :Workflow

Assessment Report

Generated from 07/15/2017 00:00 to 07/18/2017 23:59

Pt Name: [REDACTED] L MRN: 1116206
 Pt ID: 0101757329 Acct No: K20033856236
 DOB: 10/01/2013 Age/Sex: 3Y/F
 Adm DTime: 07/15/2017 08:34 Atn Dr: Craig, Anna MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Alrg: codeine, Fish Containing Products, Fish containing products

Patient Factors

Assessment Sts Complete Collected DTime 07/16/2017 07:06
 Collected By Valarie J Vann, RN

Patient Factors

Height	3.5 ft,in	How Obtained	Measured
Weight	34/13.329 lbs,oz	How Obtained	Measured
Body Mass Index	13.88	Oriented to person, place and time	No
Isolation precautions	None	Fall precautions	Yes
Requires assistance with transfers	Yes	Transportation method	Wheelchair
IV	Yes	Support person	Elizabeth Alexander (Grandmother)
O2 in use	No		

Clinical Note:

Patient Factors

Assessment Sts Complete Collected DTime 07/15/2017 15:58
 Collected By Jennifer R Lee, RN

Patient Factors

Height	3.5 ft,in	How Obtained	Measured
Weight	15.8 kg	How Obtained	Measured
Body Mass Index	13.88	Oriented to person, place and time	No
Isolation precautions	None	Fall precautions	Yes
Requires assistance with transfers	Yes	Transportation method	Wheelchair
IV	Yes	Support person	Elizabeth Alexander (Grandmother)
O2 in use	No		

Clinical Note:

Vital Signs

Assessment Sts Complete Collected DTime 07/16/2017 15:29
 Collected By Valarie J Vann, RN

Vital Signs

Temperature	98.9 F	Temperature Site	Temporal
Pulse	130	Pulse site	VS machine
Respirations	24	O2 Saturation (%)	96
Height	3.5 ft,in	How Obtained	Measured
Weight	34/13.329 lbs,oz	How Obtained	Measured

Pt Name: [REDACTED] L

MRN: 1116206

Assessment Report

Rm/ Bed:

Page 1 of 3

ORE_0010_DSCH_NBR.rpt v1.00

Printed By :Workflow

Assessment Report

Generated from 07/15/2017 00:00 to 07/18/2017 23:59

Pt Name: [REDACTED] L MRN: 1116206
 Pt ID: 0101757329 Acct No: K20033856236
 DOB: 10/01/2013 Age/Sex: 3Y/F
 Adm DTime: 07/15/2017 08:34 Attn Dr: Craig, Anna MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Allrg: codeine, Fish Containing Products, Fish containing products

Vital Signs

Assessment Sts Complete Collected DTime 07/16/2017 15:29
 Collected By Valerie J Vann, RN

Vital Signs

Body Mass Index	13.88	Ideal Body Weight, female	10.16
Ideal Body Weight, male	20.16	WFE Respiratory rate	24

Clinical Note:

Vital Signs

Assessment Sts Complete Collected DTime 07/16/2017 11:46
 Collected By Valerie J Vann, RN

Vital Signs

Temperature	98.8 F	Temperature Site	Temporal
Pulse	125	Pulse site	Cardiac monitor
Respirations	22	O2 Saturation (%)	99
Height	3.5 ft,in	How Obtained	Measured
Weight	34/13.329 lbs,oz	How Obtained	Measured
Body Mass Index	13.88	Ideal Body Weight, female	10.16
Ideal Body Weight, male	20.16	WFE Respiratory rate	22

Clinical Note:

Vital Signs

Assessment Sts Complete Collected DTime 07/16/2017 04:00
 Collected By Jennifer A Griffith, RN

Vital Signs

Temperature	97.7 F	Temperature Site	Temporal
Pulse	123	Pulse site	VS machine
Respirations	30	O2 Saturation (%)	94
Height	3.5 ft,in	How Obtained	Measured
Weight	34/13.329 lbs,oz	How Obtained	Measured
Body Mass Index	13.88	Ideal Body Weight, female	10.16
Ideal Body Weight, male	20.16	WFE Respiratory rate	30

Clinical Note:

Vital Signs

Assessment Sts Complete Collected DTime 07/15/2017 23:45
 Collected By Jennifer A Griffith, RN

Vital Signs

Temperature	97.6 F	Temperature Site	Temporal
Pulse	124	Pulse site	Cardiac monitor

Pt Name: [REDACTED] L
 Rm/ Bed:

MRN: 1116206
 Page 2 of 3

Assessment Report

ORE_0010_DSCH_NBR.rpt.v1.00

Printed By :Workflow

Printed On: 17-Jul-17 16:15

Assessment Report

Generated from 07/15/2017 00:00 to 07/18/2017 23:59

Pt Name: [REDACTED] L MRN: 1116206
Pt ID: 0101757329 Acct No: K20033856236
DOB: 10/01/2013 Age/Sex: 3Y/F
Adm DTime: 07/15/2017 08:34 Atn Dr: Craig, Anna MD
Nurs Sta: S 5 East 1 Rm & Bed:
Dx:
Alrg: codeine, Fish Containing Products, Fish containing products

Vital Signs

Assessment Sts Complete Collected DTime 07/15/2017 23:45
Collected By Jennifer A Griffith, RN

Vital Signs

Respirations	32	O2 Saturation (%)	93
Height	3.5 ft,in	How Obtained	Measured
Weight	34/13.329 lbs,oz	How Obtained	Measured
Body Mass Index	13.88	Ideal Body Weight, female	10.16
Ideal Body Weight, male	20.16	WFE Respiratory rate	32

Clinical Note:

Pt Name: [REDACTED] L
Rm/ Bed:

MRN: 1116206
Page 3 of 3

Assessment Report
ORE_0010_DSCH_NBR.rpt v1.00
Printed By: Workflow
Printed On: 17-Jul-17 16:15

ALLERGY REPORT

Pt Name: [REDACTED] L MRN: 1116206
Pt ID: 0101757329 Acct No: K20033856236
DOB: 10/01/2013 Age/Sex: 3Y/F
Adm DTime: 07/15/2017 08:34 Atn Dr: Craig, Anna MD
Nurs Sta: S 5 East 1 Rm & Bed:
Dx:
Alrg: codeine, Fish Containing Products, Fish containing products

Alrg Type	Alrg Name	Onset	Reaction	Severity	Comment
Drug	codeine	7/14/2017	Shortness of Breath	Severe	"Took codeine yesterday. Started wheezing, couldn't breathe like she was having an asthma attack"
Drug	Fish Containing Products	05/2017	Anaphylaxis	Severe	Patient severely allergic. Reaction when touches seafood
Food	Fish containing products	05/2017	Anaphylaxis	Severe	Patient severely allergic. Reaction when touches seafood

Pt Name: [REDACTED] L
Rm/ Bed:

MRN: 1116206
Page 1 of 1

Clinical Notes Report

Generated from 07/15/2017 00:00 to 07/18/2017 23:59

Pt Name: [REDACTED] L MRN: 1116206
Pt ID: 0101757329 Acct No: K20033856236
DOB: 10/01/2013 Age/Sex: 3Y/F
Adm DTime: 07/15/2017 08:34 Atn Dr: Craig, Anna MD
Nurs Sta: S 5 East 1 Rm & Bed:
Dx:
A1rg: codeine, Fish Containing Products, Fish containing products

Collected Date/Time: 07/15/17 17:13 Status: Complete

Collected By: Valarie J Vann, RN

Note: called rt to let them know that Dr craig ordered the albuterol treatments changed to q4 around the clock.

Collected Date/Time: 07/15/17 16:43 Status: Complete

Collected By: Valarie J Vann, RN

Note: Called Social services, to let them know that a patient care order was put in for socail services consult for home nebulizer because the mother said the one that the patient uses at home was broken.

Pt Name: [REDACTED] L
Rm/ Bed:

MRN: 1116206
Page 1 of 1

Clinical Notes Report
ORE_0030_DSCH_NBR_V1.rpt v1.00
Printed By: Workflow
Printed On: 17-Jul-17 16:15

Charted Interventions Report

Generated from 07/15/2017 00:00 to 07/18/2017 23:59

Pt Name: [REDACTED] L MRN: 1116206
 Pt ID: 0101757329 Acct No: K20033856236
 DOB: 10/01/2013 Age/Sex: 3Y/Female
 Adm DTime: 07/15/2017 08:34 Atn Dr: Craig, Anna MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Allrg: codeine, Fish Containing Products, Fish containing products

Scheduled Interventions

Service Type: Nursing

Service Sub Type: Activity

Order As Written: Bedrest with bathroom privileges

Order Status: Complete

Planned Start Date/Time	Actual Start Date/Time	Occurrence Status Modifier	Comment	Performed By	Supervised By
07/15/2017 13:39	07/15/2017 13:39	Complete		Valarie J Vann, RN	

Service Type: Patient Care Orders

Service Sub Type: PCO Education

Order As Written: Education, safety precautions - patient/family every 12 hr DAILY and PRN as needed

Order Status: Discontinue

Planned Start Date/Time	Actual Start Date/Time	Occurrence Status Modifier	Comment	Performed By	Supervised By
07/15/2017 16:28	07/15/2017 16:28	Complete		Valarie J Vann, RN	
07/16/2017 04:28	07/16/2017 04:28	Complete		Jennifer A Griffith, RN	
07/16/2017 16:28	07/16/2017 16:28	Complete		Valarie J Vann, RN	

Order As Written: Education, ambulation safety every 12 hr DAILY and PRN as needed

Order Status: Discontinue

Planned Start Date/Time	Actual Start Date/Time	Occurrence Status Modifier	Comment	Performed By	Supervised By
07/15/2017 16:28	07/15/2017 16:28	Complete		Valarie J Vann, RN	
07/16/2017 04:28	07/16/2017 04:28	Complete		Jennifer A Griffith, RN	
07/16/2017 16:28	07/16/2017 16:28	Complete		Valarie J Vann, RN	

Order As Written: Education, position change every 12 hr DAILY and PRN as needed

Order Status: Discontinue

Planned Start Date/Time	Actual Start Date/Time	Occurrence Status Modifier	Comment	Performed By	Supervised By
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Pt Name: [REDACTED] L

MRN: 1116206

Charted Interventions Report

Rm/ Bed:

Page 1 of 2

ORE_0129_DSCH_NBR_V1.rpt v1.00

Printed By:

Printed On: 17-Jul-17 16:15

Charted Interventions Report

Generated from 07/15/2017 00:00 to 07/18/2017 23:59

Pt Name: [REDACTED] L MRN: 1116206
 Pt ID: 0101757329 Acct No: K20033856236
 DOB: 10/01/2013 Age/Sex: 3Y/Female
 Adm DTime: 07/15/2017 08:34 Atn Dr: Craig, Anna MD
 Nurs Sta: S 5 East 1 Rm & Bed:
 Dx:
 Alrg: codeine, Fish Containing Products, Fish containing products

07/15/2017 16:28	07/15/2017 16:28	Complete	Valarie J Vann, RN
07/16/2017 04:28	07/16/2017 04:28	Complete	Jennifer A Griffith, RN
07/16/2017 16:28	07/16/2017 16:28	Complete	Valarie J Vann, RN

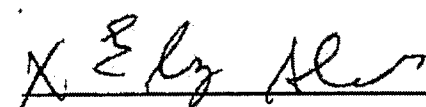
Pt Name: [REDACTED] L
 Rm/ Bed:

MRN: 1116206
 Page 2 of 2

Charted Interventions Report
 ORE_0129_DSCH_NBR_V1.rpt v1.00
 Printed By :
 Printed On: 17-Jul-17 16:15

Willis-Knighton South Discharge Instructions

116

Patient Name:	██████████ L	MRN / CID:	1116206
Date of Birth:	2013-Oct-01	Account Number:	K20033856236
Date Admitted:	2017-Jul-15 08:34 AM	Age / Sex:	3Y/F
Location:	S 5 East 1 / S5504A	Attending Physician:	Craig, Anna MD
Allergies:	codeine, Fish Containing Products, Fish containing products		
Vital Signs			
Temperature 98.8 F		Pulse 120	
Gastrointestinal			
Date of last bowel movement		07/16/2017	
Discharge Status			
Patient Discharge Instructions Summary			
Discharge Instructions Reviewed discharge instructions with patient / significant other Patient unaccompanied Patient / Significant other verbalized understanding of discharge instructions Patient / Significant other received written instructions			
Medical Referrals			
Name	When	Contact Number	
PCP, at UH	in 1-2 days		
ACTIVITY & RESTRICTIONS			
Diet	Pediatric		
Discharge Instructions			
Notify Physician For Fever or chills Temperature over 100.5 lasting more than 8 hours Shortness of breath If symptoms worsen contact your health care provider or call 911			
 Patient / Representative		_____ Witness Signature	
Date / Time		Date / Time	

Discharge Medication List

Pt Name: [REDACTED] L
Pt ID: 0101757329
DOB: 10/1/2013 12:00:00AM
Adm Dtime: 7/15/2017 8:34:00AM
Nurs Sta: S 5 East 1
Alrg: codeine, Fish Containing Products, Fish containing products

MRN: 1116206
Acct No: K20033856236
Age/Sex: 3Y/F
Attn Dr: Craig, Anna MD
Rm & Bed: S5504A

Take these Medications


☒ albuterol sulfate 2.5 mg/3 mL (0.083 %) Solution for Nebulization
Directions: 3 mL by inhalation every four hours as needed for shortness of breath
Additional Instructions:
Last Dose Given Date: _____ Time: _____
Retail Pharmacy: _____ Mail Order Pharmacy: _____
Entered By: Sharon Nhu Tran, MD

☒ amoxicillin 400 mg/5 mL Suspension for Reconstitution
Directions: 8 mL oral twice a day
Additional Instructions:
Last Dose Given Date: _____ Time: _____
Retail Pharmacy: _____ Mail Order Pharmacy: _____
Entered By: Sharon Nhu Tran, MD

Stop taking these medications

☒ **STOP**
Directions:
Reason to Stop:
Date last Given: _____

Pharmacy: Walgreens Drug Store Retail
09492
3100 N MARKET ST
SHREVEPORT LA 711074005
Phone # 3186811083
Fax # 3186819522



Patient Signature Date / Time

Witness Signature Date / Time



ASSIGNMENT OF BENEFITS

1. Hospital Care Consent: I/wc consent to hospital services, treatment and diagnostic procedures by the hospital as may be deemed necessary or advisable by my physician and/or consultants selected by my physician. The consent to hospital care includes permission for x-ray examinations, laboratory procedures, I.V. treatments, hepatitis test administration of blood and blood products, injections, medications, recording, filming or video monitoring for internal purposes only, and hospital services rendered the patient under the general and special instruction of doctors. The patient acknowledges responsibility for any or all of these procedures. It is the hospital policy that the patient has the opportunity to discuss surgery and procedures with the patient's doctor before hand. The patient has the right to consent to surgery and procedures. Except in emergencies or unusual circumstances, the hospital does not allow its facilities to be used without this discussion and patient's consent. I voluntarily give my consent to hospital care and accept the condition of hospitalization listed.

2. Authorizations for Release of Information: The employees and agents of this hospital and copy services and electronic claims processing services under contract with this hospital and any third party billing agents for this hospital or any of its staff physicians involved with patient care are given permission to release any and all information relating to the patient, including but not limited to the medical record of the patient's hospitalization, to another healthcare provider if the patient was transferred to that facility from this hospital and to any and all insurance companies or other third-party paying or obligated to pay, in whole or in part, the charges incurred by the patient in this hospital; and they are also given permission to release the above described information to any agent or firm working for or with the above described insurance companies or other third-party payors for the purpose of performing pre-certification, concurrent and/or retrospective review and/or other utilization review of any kind.

3. Valuables: I understand and acknowledge that the hospital assumes no responsibility for personal possessions including cash, jewelry, bridgework, eyeglasses or any other personal possession which I choose to keep in my room. I have been advised that such valuables should be placed in the care of my family or deposited in the hospital vault located in the Business Office.

4. Safety Code for Hospital: Safety Codes for hospitals issued by the National Fire Protection Association prevent the use in the hospital of any electrical equipment or accessories until they have been safety checked by the hospital's electrical engineer. Exceptions to this rule are hair and blow dryers, curling irons, hot rollers, radios, clocks, electric razors, shavers, contact lens sterilizers, electric toothbrushes and calculators.

5. Payment Guaranty and Assignment of Insurance Benefits: I, the undersigned patient, guardian, and/or guarantor (hereinafter "Debtor") hereby promise to pay in full Willis-Knighton Health System (WKHS) customary charges for the goods and services rendered to the patient identified on the reverse side hereof during this period of hospitalization (hereinafter "Indebtedness"). Debtor acknowledges and agrees that, unless waived in full by WKHS as set forth below, the Indebtedness accruing during this hospitalization is due and payable in such amounts and at such times during this hospitalization as WKHS may, in its sole discretion, determine, that the entire Indebtedness is due and payable in full at discharge. I acknowledge that, upon proof of acceptable insurance coverage, WKHS, in its sole discretion, may reduce the amount of indebtedness due and payable during this hospitalizations and the balance due at discharge. In such event, I understand that all deductibles, co-insurance, non-covered charges and other items not paid by insurance or other third-party payors shall be due and payable during this period of hospitalization and upon discharge as set forth hereinabove. I acknowledge and agree that in the event that WKHS, in its sole discretion, accepts proof of insurance coverage, claims for payment for benefits will be filed on behalf of the Debtor and/or the insured and that these benefits will be considered by WKHS in determining the amounts due as set forth hereinabove. I understand and agree that WKHS will accept payments from third-party payors and insurers on behalf of the Debtor and apply such payment to the indebtedness to the extent that they are received. I acknowledge and agree that the filing of such insurance and other third-party claims is performed as a service by WKHS and in no way relieves me of the obligation to pay the Indebtedness as agreed herein above.

Patient hereby appoints WKMC as Patient's authorized representative to file any necessary claim appeal(s) on Patient's behalf. In consideration for this appointment, WKMC agrees only to collect only applicable copayments, deductibles, and coinsurance for covered benefits from the Patient and waives any right to collect any other payments related to those covered benefits from the Patient.

Debtor hereby absolutely assigns to WKHS all insurance benefits on all policies of insurance under which Debtor is an insured, whether hospital, medical, liability or other insurance, and also hereby absolutely assigns to WKHS the proceeds of any judgment or settlement of any claim against any third party and any and all other amounts which may be determined in any manner to be payable to Debtor in connection with any injury suffered by the patient which gives rise to the Indebtedness incurred during this period of treatment. I hereby authorize WKHS to obtain any and all information related to such injuries, including, but not limited to, accident reports and agree to cooperate with WKHS in connection with the procurement of any information or documents WKHS deems in its sole discretion, necessary or appropriate in connection with the assignment made pursuant to this paragraph. I hereby authorize and direct that all such payments and proceeds shall be made directly to WKHS under the terms of this assignment. Any receipts from WKHS shall be applied towards Indebtedness but such application shall not relieve the Debtor from the Debtor's obligation to pay any remaining portion to the Indebtedness. Debtor acknowledges and agrees that, to the extent that the Indebtedness has not been satisfied by such receipts, that portion of the Indebtedness for which payment has been deferred pursuant to the preceding paragraph shall be due and payable in full on the thirtieth day following the date of service. In the event that WKHS receives proceeds and/or payments in excess of the Indebtedness, WKHS may apply such excess payment to any outstanding Indebtedness of Debtor to WKHS arising out of any other period(s) of treatment as well as any attorneys' fees and expenses for which Debtor may be liable hereunder. In the event that all Indebtedness has been paid

Admission Date: 07/15/17

Admission Time: 0834



10/01/13 3Y F
Aycok II, Richard A M.D.
K20033856236 07/15/17



ASSIGNMENT OF BENEFITS

in full, then WKHS will refund the Debtor any such excess payment. Notwithstanding anything herein to the contrary, the assignments made hereby shall remain in full force and effect until the entire Indebtedness and any and all attorneys' fees and expenses for which Debtor may be liable have been paid in full. In the event that the Indebtedness is not paid when and as due as determined by WKHS hereunder, and the Indebtedness is placed in the hands of an attorney for purposes of collection, Debtor agrees to pay reasonable attorneys' fees, which are hereby acknowledged to be one-third (1/3) of the amount of the Indebtedness at the time the matter is placed in the hands of an attorney, plus any and all court costs and other expenses incurred in connection with the collection of the Indebtedness.

Financial assistance is available to all patients who meet the requirements of our charity care policy. Patients are encouraged to contact the Business Office if they have any concerns or need assistance in paying their bills. Our charity care policy is limited to hospital charges and does not include physician, anesthesiologist or professional charges that are not billed by the hospital. In addition, financial assistance is not offered for cosmetic, elective, experimental or other treatments and all hospital services must be ordered by your physician.

6. Assignment to Physicians: I understand that my physician as well as other physicians who treat me or otherwise involved in my care while a patient at the hospital are not employees or agents of the hospital and the hospital is not responsible for their actions. I further understand that my physician or other physicians will send me a separate bill for their services, in addition to the hospital bill. I hereby assign to all physicians who treat me the benefits due to me for these services covering medical and/or surgical expenses. I agree that should be the amount be insufficient to cover the entire medical/surgical expense, I will be responsible to said physicians for payment of the entire bill.

7. Medicare Consent: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act (SSA) is correct. I authorize Willis-Knighton Health System (WKHS) to provide (SSA) or its intermediaries with access to my medical/hospital record for the purpose of processing the Medicare claim for this or a related Medicare claim. I further request that WKHS provide such copies thereof as may be requested. Copies may be made by WKHS or its agents or contractors providing copy service and electronic claims processing services and said third party billing agents for hospital and staff physicians involved with patient care.

8. Champus/Medicare Notice: Champus/Medicare will not pay for private rooms unless medical justified, personal convenience items, diagnostic admissions or test or hospital stays not medically necessary. My signature below acknowledges my receipt of this information regarding Champus/Medicare from the hospital on the date indicated.

9. Willis-Knighton Health System (and our Medical Staff) will use and disclose your personal health information to treat you, to receive payment for the care we provide and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website and have copies available for distribution. I acknowledge that I have received a copy of the Notice of Privacy Practices.

This form has been fully explained to me. My signature reflects my understanding of the information contained herein. I further understand and acknowledge that all references to myself as the patient shall be deemed to apply as if rewritten in their entirety to a dependent for whom I am responsible for and/or who is unable to consent on their behalf for reasons indicated below.

I acknowledge that I have been informed of my rights and obligations as a patient.

Signature of Patient/Guardian	Guarantor	Witness
Date/Time	Date/Time	Date/Time
Print Name	Print Name	Print Name

If Patient/Guarantor is unable to sign, I, _____, do hereby state that I have been given the authority to sign for

_____, either expressed or implied and that he or she is fully aware of this authority.

_____ Signature of Authorized Party	_____ Authorized Party's Relationship to the Patient	_____ Date/Time	_____ Witness	_____ Date/Time
---	--	--------------------	------------------	--------------------

Admission Date: 07/15/17
Admission Time: 0834



AM0005



HENDERSON L
10/01/13 3Y F
Aycock II, Richard A M.D.
K20033856236 07/15/17

WILLIS-KNIGHTON MEDICAL CENTER

SHREVEPORT, LA

EMERGENCY ROOM REGISTRATION INFORMATION (3008)

NAME: [REDACTED] L

ACCT. NO: K20033853092

GUARANTOR: ALEXANDER,JENNIFER

NEXT OF KIN: ALEXANDER,JENNIFER

ADDRESS: 3011 KITTY LN APT B
SHREVEPORT,LA 71107

ADDRESS: 2247 LEGARDY STREET
SHREVEPORT,LA 71107

PHONE: (318)210-3821

PHONE: (318)210-3821 RELATION: PARENT

GUAR EMPLOYER: CHILD

ADDRESS:

ARRIVED FROM: C

ATTENDING PHYS: Willis Jr, Fred Spence M.D.

PHONE:

ADMIT/OTHER PHYS:

PRIM CARE PHYS:

	NAME	POLICY #	GROUP #	BENEFIT PLAN
PRIMARY INS;	LA HLTHCARE CONN LA ME	1997286459512	[REDACTED] L	MEDICAID
SECONDARY INS:				
TERTIARY INS:				
FOURTH INS:				

ACCT NO: K20033853092

DATE: 07/14/17

UNIT#: K000629604

ROOM:

TIME: 1008

F/C: MA

STATUS: REG ER

SERV/LOC: ERS

SS#: 338-89-3614

PATIENT: [REDACTED] L

BIRTHDATE: 10/01/13

ADDRESS: 2247 LEGARDY STREET
SHREVEPORT,LA 71107

AGE: 3Y

SEX: F

PHONE: (318)210-3821

RACE BLACK OR AFRICAN AME

RELIGION:

COUNTY: CADDO PARISH

MARITAL STAT: SINGLE

EMPLOYER: GOD'S GIFT

PERSON TO NOTIFY: ALEXANDER,JENNIFER

ADDRESS: 2305 MARIAN PL
SHREVEPORT,LA 71109
000-0000

ADDRESS: 2247 LEGARDY STREET
SHREVEPORT,LA 71107

PHONE: (318)210-3821

RELATION: PARENT

Is the Patient here for Pre-Op Testing:

Comments:

Admit Clerk: HARTJAM

Reason for Visit: COLD SYMPTOMS

Baby ID#:

Known Drug Allergies: NKDA

HIPPA Notice Given: Y

Date Notice Given: 09/23/14

Device Id: AMSPC5

Interpreter ID Number:

Patient Survey: N

Preferred Language: ENGLISH

Ethnicity: NHILAT

Do you have an advaced directive that you would like to present to us today? N



K20033853092

Physician Documentation

Willis Knighton South

Name: Aaliyah [REDACTED]
Age: 3 yrs Sex: Female DOB: 10/01/2013
Arrival Date: 07/14/2017 Time: 10:08
Bed Post IM3

MRN: 1116206
Account#: K20033853092
Private MD: LSU/UH, KidMed clinic

HPI:

07/14 This 3 yrs old Black/African Am Female presents to ED via Carried with complaints of **Cold Symptoms**. sw2/stj
10:15
10:15 The patient presents to the emergency department with congestion, cough, earache, of the left ear. sw2/stj
10:15 Onset: The symptoms/episode began/occurred yesterday. Associated signs and symptoms: The patient sw2/stj
has no apparent associated signs or symptoms. Modifying factors: The patient symptoms are alleviated by
nothing, the patient symptoms are aggravated by nothing. Treatment prior to arrival: none. The patient has
not experienced similar symptoms in the past. The patient has not recently seen a physician.

Historical:

- Allergies: Seafood;
- Home Meds:
 1. albuterol sulfate 1.25 mg/3 mL Nebulizer nebu as needed
- PMHx: Asthma
- PSHx: None

Historical:

10:15 The history from nurses notes was reviewed and confirmed. History obtained from mother. sw2/stj
10:26 Family history: No immediate family members are acutely ill. Immunization history: Childhood bf1
immunizations up to date, Last flu immunization: up to date. Last tetanus immunization: up to date. Social
history: The patient lives at home with family The patient speaks fluent English, the patient is a minor.

ROS:

10:15 ROS as in the HPI, and all other systems were reviewed negative, or noncontributory, except as mentioned sw2/stj
below. **Constitutional:** Negative for fever, chills, and weight loss, **Eyes:** Negative for injury, pain,
and swelling, **Cardiovascular:** Negative for chest pain, palpitations, and edema, **Abdomen/GI:** Negative
for abdominal pain, nausea, vomiting, diarrhea, and constipation, **Back:** Negative for injury and pain, **GU:**
Negative for injury, bleeding, discharge, and swelling, **MS/Extremity:** Negative for injury and deformity,
Skin: Negative for injury, rash, and discoloration, **Neuro:** Negative for headache, weakness, numbness,
tingling, and seizure. **ENT:** Positive for pain left ear pulling at ears, rhinorrhea, sinus congestion, Negative
for difficulty handling secretions, difficulty swallowing, hoarseness, sore throat. **Respiratory:** Positive for
cough; Negative for dyspnea on exertion, hemoptysis, shortness of breath, wheezing.

Exam:

10:15 sw2/stj
Constitutional: Well developed, well nourished child who is awake, alert and cooperative with no acute
distress.
Head/Face: Normocephalic, atraumatic.
Eyes: PERRLA, EOMI. Normal conjunctiva with no evidence of injection or discharge. Sclera are non-icteric.
No gross corneal defects and anterior chambers appear normal by gross inspection.
Neck: Supple. Trachea midline. No lymphadenopathy or masses. Normal ROM with no evidence of
vertebral point tenderness. No meningismus. Lymphatic No abnormal lymphadenopathy noted by palpation
in the neck or axilla
Chest/axilla: Normal symmetrical motion. No tenderness. No crepitus. No axillary masses or tenderness.
Cardiovascular: Regular rate and rhythm with normal S1 and S2. no murmurs, rubs or gallops. Pulses
intact and symmetrical throughout. No edema or JVD.
Respiratory: CTA with excellent breath sounds in all fields. Symmetrical chest wall movement with no
wheezing, rales, or rhonchi. No evidence of stridor or nasal flaring.
Abdomen/GI: Soft, non-tender with normal bowel sounds. No distension, tympany or bruits. No guarding,
rebound or rigidity. No palpable masses or evidence of tenderness with thorough palpation.
Back: Normal inspection with no obvious deformity. No spinal or CVA tenderness. Normal ROM without
pain

Physician Documentation Con't.

Skin: Warm and dry with excellent turgor. capillary refill <2 seconds. No cyanosis, pallor, rash or edema.
MS/ Extremity: No evidence of focal tenderness or deformity. Full ROM throughout with no evidence of weakness.

Neuro: Awake, alert, with age appropriate mental status. CN 2-12 grossly intact. Motor strength 5/5 throughout with sensory grossly intact. Age appropriate cerebellar function. Age appropriate ambulatory ability.

10:52

sw2/stj

ENT: External ear(s): are unremarkable, no acute changes, Ear canal(s): are normal, no acute changes, TM's: dullness, on the left, erythema, on the left, Examination of the other ear shows no obvious abnormality, Nose: is normal, no acute changes, Mouth: is normal, Oral mucosa: moist, Posterior pharynx: is normal, airway is patent, no erythema, no exudate.

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Height	Pain	Staff
10:19		132	28	98.5	96% on R/A	16.78 kg / 36 lbs 16 oz	31 in. (78.74 cm)		jcm

10:19 Body Mass Index 27.07 (16.78 kg, 78.74 cm)

jcm

Glasgow Coma Score:

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
10:12	spontaneous(4)	oriented(5)	obeys commands(6)		15	jcm

MDM:

10:13 Patient medically screened.

sw2

10:15

sw2/stj

Data reviewed: vital signs, nurses notes.

Counseling: I had a detailed discussion with the patient and/or guardian regarding: the historical points, exam findings, and any diagnostic results supporting the discharge/admit diagnosis.

11:21

sw2

Differential diagnosis: bacterial infection, bronchitis, fever, gastroenteritis, meningitis, pneumonia URI, UTI, viral infection.

Data interpreted: Pulse oximetry: normal.

Response to treatment: the patient's symptoms have markedly improved after treatment.

Order	Status	Time	By	For
Chest 2 View *routine*	Ordered	07/14/17 10:41	sw2	sw2
	Reviewed	07/14/17 11:21	Fred Willis	
Notes: Bed Name: 16-A	Order Method: Electronic			
Interpretation: NEGATIVE ACUTE.				
WEIGHT?: (OERDWEIGHT): 16.78				
ER EXAM ROOM/BED: (OERDERRMBD): 16-A				
Is the patient able to bear weight? (OERDBEARWT):				
Is the patient at risk for falls? (OERDFALLS):				
MODE OF TRANSPORTATION : (OERDTRANS): Stretcher				
O2: (OEADO2): No				
Priority RAD: Stat				
REASON FOR EXAM: (OERDEXAM): Cold Symptoms				

Name: Aaliyah [REDACTED]

MRN: 1116206

Account#: K20033853092

Print Time: 7/15/2017 16:18:22

Page 2 of 3

Physician Documentation Con't.

Order	Status	Time	By	For
Call X-Ray Tech	Ordered	07/14/17 10:41	sw2	sw2
	Completed	07/14/17 10:45	Steven Clinger	
Notes:	Order Method: Electronic			
Order	Status	Time	By	For
Rocephin 500 mg with Lidocaine 1% as diluent - (Rocephin 500 mg, Lidocaine 1 mL) IM once	Ordered	07/14/17 10:59	sw2	sw2
	Administered	07/14/17 11:36	bf1	
Notes:	Order Method: Electronic			
07/14/17 11:36	Administered: Rocephin 500 mg with Lidocaine 1% as diluent - (Rocephin 500 mg, Lidocaine 1 mL) IM in left ventrogluteal			bf1

Order Signatures:

Willis, Fred, MD MD sw2

Scribe Statement:

07/14

10:15 Scribed for **Dr. Fred S Willis, Jr., MD** by Samuel T Jorden, Scribe

sw2/stj

Disposition:

11:21 Electronically signed by: FRED WILLIS JR MD. I personally performed the services described in this documentation as scribed in my presence and it is both accurate and complete. Disposition. Chart complete.

sw2

11:23 Disposition.

sw2

Disposition:

07/14/17 11:22 Discharged to Home/Self Care. Impression: ACUTE BRONCHITIS, ACUTE OTITIS MEDIA.

- Condition is Stable.
- Discharge Instructions: Otitis Media, Pediatric.
- Prescriptions for
 - Amoxicillin 400 mg/5 mL Oral Suspension for Reconstitution
 - take 10.1 milliliter by ORAL route every 12 hours for 10 days MAX dose = 1750mg/day; 200 milliliter.
 - acetaminophen.
 - codeine 120-12 mg/5 mL Oral Suspension - take 2.5 milliliter by ORAL route every 4-6 hours As needed as needed; 60 milliliter.
- Follow up: LSU/UH, KidMed clinic; When: Tomorrow.
- Problem is new.
- Symptoms have improved.

Signatures:

Dispatcher MedHost	EDMS	Clinger, Steven, RN	RN	smc
Mathews, Janet, RN	RN	jcm	Willis, Fred, MD	MD sw2
Figueiredo, Brittani, RN	RN	bf1	Jorden, Samuel, Scribe	Scribe stj

Name: Aaliyah

MRN: 1116206
Account#: K20033853092

Nurse's Notes

Name: Aaliyah [REDACTED]
Age: 3 yrs **Sex:** Female **DOB:** 10/01/2013
Arrival Date: 07/14/2017 **Time:** 10:08
Bed Post IM3

Willis Knighton South

MRN: 1116206
Account#: K20033853092
Private MD: LSU/UH, KidMed clinic

Presentation:

07/14 Method of Arrival: Carried. jcm
 10:12 Preferred language for medical communication is English. Presenting complaint: Mother states: Cold symptoms and pulling at left ear. Person Transporting: Parent. Transition of care: patient was not received from another setting of care. jcm
 10:18 Acuity: 4 - Semi-Urgent. jcm

Triage Assessment:

10:12 **General:** Appears in no apparent distress, well developed, well nourished, Behavior is cooperative, appropriate for age, restless, mobility; ambulates without assistance Denies fever. **Pain:** FACES pain scale score is 0 out of 10. jcm

Historical:

- **Allergies:** Seafood;
- **Home Meds:**
1. albuterol sulfate 1.25 mg/3 mL Nebulizer nebu as needed
- **PMHx:** Asthma
- **PSHx:** None

Historical:

10:15 The history from nurses notes was reviewed and confirmed. History obtained from mother. sw2/stj
 10:26 Family history: No immediate family members are acutely ill. Immunization history: Childhood immunizations up to date, Last flu immunization: up to date. Last tetanus immunization: up to date. Social history: The patient lives at home with family The patient speaks fluent English, the patient is a minor. bf1

Screening:

10:12 **Abuse screen:** there are no obvious signs of child abuse. jcm
Patient fall risk assessment; risks identified; None.
Learning Barriers: age barrier identified, caregiver ready and willing to learn.
Pedi Fall Risk None Identified.
Exposure risk/Travel Screening: None identified.

Assessment:

10:26 **Pain:** Denies pain. level that is acceptable is 0 out of 10 on a pain scale. **General:** Appears in no apparent distress, well developed, Behavior is cooperative, appropriate for age, mobility; ambulates without assistance Reports feeling ill for 1-2 days. **Neuro:** Level of Consciousness is alert, awake, obeys commands, Oriented to person, place, time. **EENT:** Nares with drainage noted bilaterally Reports nasal discharge that is watery. **Cardiovascular:** Capillary refill < 3 seconds is brisk in bilateral fingers. **Respiratory:** Respiratory effort is even, unlabored, Respiratory pattern is regular, symmetrical, Airway is patent Breath sounds are clear bilaterally. Parent/caregiver reports the patient having cough that is non-productive. **Gastrointestinal:** Abdomen is flat, non-distended Denies nausea, pain, vomiting. **Musculoskeletal:** No deficits noted. bf1

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Height	Pain	Staff
10:19		132	28	98.5	96% on R/A	16.78 kg / 36 lbs 16 oz	31 in. (78.74 cm)		jcm

10:19 Body Mass Index 27.07 (16.78 kg, 78.74 cm) jcm

Nurse's Notes Con't**Vitals:**

10:12 Acuity: 4 - Semi-Urgent.

jcm

Glasgow Coma Score:

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
10:12	spontaneous(4)	oriented(5)	obeys_commands(6)		15	jcm

ED Course:

10:08 Patient arrived in ED. ms2
 10:08 Patient moved to KIOSK. ms2
 10:12 LSU/UH, KidMed clinic is Private Physician. jcm
 10:13 Figueiredo, Brittani, RN is Primary Nurse. bf1
 10:13 Patient moved to 16-A. bf1
 10:13 Willis, Fred, MD is Attending Physician. sw2
 10:27 Patient/caregiver encouraged to voice any concerns. Bed in low position. Call light in reach. Instructed to call for assist when getting up, verbalized understanding. Patient has correct armband on for positive identification. Adult with patient. Door closed. Noise minimized. Updated on plan of care, patient verbalized understanding. bf1
 11:02 Patient moved to Radiology. tm9
 11:02 Patient moved to 16-A. tm9
 11:02 Chest 2 View *routine* Sent. tm9
 11:21 LSU/UH, KidMed clinic is Referral Physician. sw2
 11:37 No procedures done that require assistance. bf1
 11:53 Special Handling: Hold Discharge. bf1
 12:14 Patient moved to Post IM3. lmm

Administered Medications:

Time	Drug & Dose <i>Dispensable & Quantity</i>	Volume	Route	Rate	Infused Over	Site	Delivery	Staff
11:36	Rocephin 500 mg with Lidocaine 1% as diluent - (Rocephin 500 mg, Lidocaine 1 mL)		IM			left ventrogluteal		bf1

Outcome:

11:22 Discharge ordered by MD. sw2
 11:37 Discharged to home, carried, with family. Discharge instructions given to patient, family, Instructed on discharge instructions, follow up and referral plans, medication usage; Demonstrated understanding of instructions, medications, No questions or concerns expressed to me at discharge. No belongings were removed by WK staff. **Medication reconcilliation form provided. Med Effects:** Effects of administered medications were addressed. **Oxygen use:** Oxygen use not applicable. bf1
 13:51 Electronic medical record closed. jcm

Signatures:

Mathews, Janet, RN	RN	jcm	Willis, Fred, MD	MD	sw2
Scriptuser, MEDHOST		ms2	Figueiredo, Brittani, RN	RN	bf1
Morrow, Latarsha, RN	RN	lmm	Jorden, Samuel, Scribe	Scribe	stj

Name: Aaliyah [REDACTED]

MRN: 1116206

Account#: K20033853092

Nurse's Notes Con't

Moore, Tracy, RT

RT tm9

Name: Aaliyah [REDACTED]

Print Time: 7/15/2017 16:18:20

MRN: 1116206
Account#: K20033853092
Page 3 of 3

Willis-Knighton South
2510 Bert Kouns Industrial Loop
Shreveport, LA 71118

Patient Name: [REDACTED]
Adm No: K20033853092
DOB: 10/01/2013
Age: 3Y F
Corp ID: 000001116206

MRN: 1116206
Location: ER Patient - ERS-
Ord No: 90015
Hospital: WKS

Ordering Dr: FRED SPENCER WILLIS JR

CC:

Final Report

Admitting Diagnosis: COLD SYMPTOMS
Reason For Exam: Cold Symptoms
Procedure Date: 07/14/2017
Procedure: SXR - XR, chest 2 view

Interpretive Location: WKP
Accession Number: 3703223
CPT Code: 71020

IMPRESSION: No acute cardiopulmonary disease.

RESULT:

Procedure: XR, chest 2 view

Clinical Information: Cold Symptoms

Comparison: 4/12/2017

Findings:

Cardiomediastinal silhouette normal. Trachea midline. Pulmonary vasculature normal. No perihilar opacity or confluence consolidation present. No pneumothorax or pleural effusion seen. Aortic arch and stomach bubble are left-sided. Osseous structures normal.

Electronically Signed by: KOREY PATRICK BURGIN M.D. on Jul 14 2017 11:08A

Techs: Tracy Giddings Moore
Additional Staff:

Read by: KOREY PATRICK BURGIN M.D. on Jul 14 2017 11:07A
Electronically Signed by: KOREY PATRICK BURGIN M.D. on Jul 14 2017 11:08A

Printed: Jul 14 2017 11:12AM

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RUN DATE: 07/14/17
RUN TIME: 1015
RUN USER: HARTJ.AM

Willis Knighton Smith *ADMISSION
INTERDISCIPLINARY ALLERGY SOURCE DOCUMENT

PAGE 1

Name: [REDACTED] L DOB: 10/01/13 Age: 3Y 09M
Rm/Bd: Serv/Lochn: ERS Status: ER Sex: F
Unit#: K000629604 Account#: K20033853092 EPI#: 000000001116206

Last Update/
Acknowledgement:

Interdisciplinary Assessment (Free Text), historical data:

Allergy1-Med/Contact: NKDA	11/04/16 - 2201
Allergy2-Med/Contact: NKDA	11/04/16 - 2201
Food Allergies-Intol: NKFA	11/04/16 - 2201
Latex Allergy (Y/N): N	11/04/16 - 2201

Interdisciplinary Allergy Source Document is a Permanent Part of
the Patient's Medical Record



[REDACTED] L
10/01/13 3Y 09M
Willis Jr, Fred Spe
K20033853092 07/14/17

Willis Knighton South and Center for Womens Health

Willis Knighton South
2510 Bert Kouns Industrial Loop
Shreveport, LA 71118
318-212-5500



Discharge Instructions for: [REDACTED]

Arrival Date: 07/14/2017 10:08

Care Complete Time: 07/14/2017 11:22

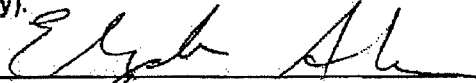
Thank you for choosing Willis Knighton South for your care today. The examination and treatment you have received in the Emergency Department today have been rendered on an emergency basis only and are not intended to be a substitute for an effort to provide complete medical care. You should contact your follow-up physician as it is important that you let him or her check you and report any new or remaining problems since it is impossible to recognize and treat all elements of an injury or illness in a single emergency care center visit.


Care provided by: Willis, Fred, MD

Diagnosis: ACUTE BRONCHITIS; ACUTE OTITIS MEDIA

DISCHARGE INSTRUCTIONS	FORMS
Otitis Media, Pediatric	None
FOLLOW UP INSTRUCTIONS	PRESCRIPTIONS
LSU/UH, KidMed clinic When: Tomorrow	Amoxicillin acetaminophen-codeine
SPECIAL NOTES	
None	

I hereby acknowledge that I have received and understand the above instructions and prescriptions (if any).

ⓧ 
Aaliyah Henderson
MRN # 1116206


ED Physician or Nurse

X-RAYS and LAB TESTS:

If you had x-rays today they were read by the emergency physician. Your x-rays will also be read by a radiologist within 24 hours. If you had a culture done it will take 24 to 72 hours to get the results. If there is a change in the x-ray diagnosis or a positive culture, we will contact you. Please verify your current phone number prior to discharge at the check out desk.

MEDICATIONS:

If you received a prescription for medication(s) today, it is important that when you fill this you let the pharmacist know all the other medications that you are on and any allergies you might have. It is also important that you notify your follow-up physician of all your medications including the prescriptions you may receive today.

Chart Copy



10/01/13 3Y 09M L
Willis Jr, Fred Spe
K20033853092 07/14/17

FOLLOW UP INSTRUCTIONS

LSU/UH, KidMed clinic (LSU / University Clinic)

318-626-0015

When: Tomorrow

PRESCRIPTIONS

Amoxicillin 400 mg/5 mL Oral Suspension for Reconstitution

Printed

Take 10.1 milliliter by ORAL route every 12 hours for 10 days MAX dose = 1750mg/day; Quantity: 200 milliliter

acetaminophen-codeine 120-12 mg/5 mL Oral Suspension

Printed

Take 2.5 milliliter by ORAL route every 4-6 hours As needed as needed; Quantity: 60 milliliter

TESTS AND PROCEDURES

Labs

None

Rad

Chest 2 View *routine*

Procedures

None

Other

Call X-Ray Tech



HENDERSON [REDACTED] L
10/01/13 3Y 09M
Willis Jr, Fred Spe
K20033853092 07/14/17



ASSIGNMENT OF BENEFITS

1. Hospital Care Consent: I/we consent to hospital services, treatment and diagnostic procedures by the hospital as may be deemed necessary or advisable by my physician and/or consultants selected by my physician. The consent to hospital care includes permission for x-ray examinations, laboratory procedures, I.V. treatments, hepatitis test administration of blood and blood products, injections, medications, recording, filming or video monitoring for internal purposes only, and hospital services rendered the patient under the general and special instruction of doctors. The patient acknowledges responsibility for any or all of these procedures. It is the hospital policy that the patient has the opportunity to discuss surgery and procedures with the patient's doctor before hand. The patient has the right to consent to surgery and procedures. Except in emergencies or unusual circumstances, the hospital does not allow its facilities to be used without this discussion and patient's consent. I voluntarily give my consent to hospital care and accept the condition of hospitalization listed.

2. Authorizations for Release of Information: The employees and agents of this hospital and copy services and electronic claims processing services under contract with this hospital and any third party billing agents for this hospital or any of its staff physicians involved with patient care are given permission to release any and all information relating to the patient, including but not limited to the medical record of the patient's hospitalization, to another healthcare provider if the patient was transferred to that facility from this hospital and to any and all insurance companies or other third-party paying or obligated to pay, in whole or in part, the charges incurred by the patient in this hospital; and they are also given permission to release the above described information to any agent or firm working for or with the above described insurance companies or other third-party payors for the purpose of performing pre-certification, concurrent and/or retrospective review and/or other utilization review of any kind.

3. Valuables: I understand and acknowledge that the hospital assumes no responsibility for personal possessions including cash, jewelry, bridgework, eyeglasses or any other personal possession which I choose to keep in my room. I have been advised that such valuables should be placed in the care of my family or deposited in the hospital vault located in the Business Office.

4. Safety Code for Hospital: Safety Codes for hospitals issued by the National Fire Protection Association prevent the use in the hospital of any electrical equipment or accessories until they have been safety checked by the hospital's electrical engineer. Exceptions to this rule are hair and blow dryers, curling irons, hot rollers, radios, clocks, electric razors, shavers, contact lens sterilizers, electric toothbrushes and calculators.

5. Payment Guaranty and Assignment of Insurance Benefits: I, the undersigned patient, guardian, and/or guarantor (hereinafter "Debtor") hereby promise to pay in full Willis-Knighton Health System (WKHS) customary charges for the goods and services rendered to the patient identified on the reverse side hereof during this period of hospitalization (hereinafter "Indebtedness"). Debtor acknowledges and agrees that, unless waived in full by WKHS as set forth below, the Indebtedness accruing during this hospitalization is due and payable in such amounts and at such times during this hospitalization as WKHS may, in its sole discretion, determine, that the entire Indebtedness is due and payable in full at discharge. I acknowledge that, upon proof of acceptable insurance coverage, WKHS, in its sole discretion, may reduce the amount of indebtedness due and payable during this hospitalizations and the balance due at discharge. In such event, I understand that all deductibles, co-insurance, non-covered charges and other items not paid by insurance or other third-party payors shall be due and payable during this period of hospitalization and upon discharge as set forth hereinabove. I acknowledge and agree that in the event that WKHS, in its sole discretion, accepts proof of insurance coverage, claims for payment for benefits will be filed on behalf of the Debtor and/or the insured and that these benefits will be considered by WKHS in determining the amounts due as set forth hereinabove. I understand and agree that WKHS will accept payments from third-party payors and insurers on behalf of the Debtor and apply such payment to the indebtedness to the extent that they are received. I acknowledge and agree that the filing of such insurance and other third-party claims is performed as a service by WKHS and in no way relieves me of the obligation to pay the Indebtedness as agreed herein above.

Patient hereby appoints WKMC as Patient's authorized representative to file any necessary claim appeal(s) on Patient's behalf. In consideration for this appointment, WKMC agrees only to collect only applicable copayments, deductibles, and coinsurance for covered benefits from the Patient and waives any right to collect any other payments related to those covered benefits from the Patient.

Debtor hereby absolutely assigns to WKHS all insurance benefits on all policies of insurance under which Debtor is an insured, whether hospital, medical, liability or other insurance, and also hereby absolutely assigns to WKHS the proceeds of any judgment or settlement of any claim against any third party and any and all other amounts which may be determined in any manner to be payable to Debtor in connection with any injury suffered by the patient which gives rise to the Indebtedness incurred during this period of treatment. I hereby authorize WKHS to obtain any and all information related to such injuries, including, but not limited to, accident reports and agree to cooperate with WKHS in connection with the procurement of any information or documents WKHS deems in its sole discretion, necessary or appropriate in connection with the assignment made pursuant to this paragraph. I hereby authorize and direct that all such payments and proceeds shall be made directly to WKHS under the terms of this assignment. Any receipts from WKHS shall be applied towards Indebtedness but such application shall not relieve the Debtor from the Debtor's obligation to pay any remaining portion to the Indebtedness. Debtor acknowledges and agrees that, to the extent that the Indebtedness has not been satisfied by such receipts, that portion of the Indebtedness for which payment has been deferred pursuant to the preceding paragraph shall be due and payable in full on the thirtieth day following the date of service. In the event that WKHS receives proceeds and/or payments in excess of the Indebtedness, WKHS may apply such excess payment to any outstanding Indebtedness of Debtor to WKHS arising out of any other period(s) of treatment as well as any attorneys' fees and expenses for which Debtor may be liable hereunder. In the event that all Indebtedness has been paid

Admission Date: 07/14/17

Admission Time: 1008



AM0005



L
10/01/13 3Y F
Willis Jr, Fred Spence M.D.
K20033853092 07/14/17



ASSIGNMENT OF BENEFITS

in full, then WKHS will refund the Debtor any such excess payment. Notwithstanding anything herein to the contrary, the assignments made hereby shall remain in full force and effect until the entire Indebtedness and any and all attorneys' fees and expenses for which Debtor may be liable have been paid in full. In the event that the Indebtedness is not paid when and as due as determined by WKHS hereunder, and the Indebtedness is placed in the hands of an attorney for purposes of collection, Debtor agrees to pay reasonable attorneys' fees, which are hereby acknowledged to be one-third (1/3) of the amount of the Indebtedness at the time the matter is placed in the hands of an attorney, plus any and all court costs and other expenses incurred in connection with the collection of the Indebtedness.

Financial assistance is available to all patients who meet the requirements of our charity care policy. Patients are encouraged to contact the Business Office if they have any concerns or need assistance in paying their bills. Our charity care policy is limited to hospital charges and does not include physician, anesthesiologist or professional charges that are not billed by the hospital. In addition, financial assistance is not offered for cosmetic, elective, experimental or other treatments and all hospital services must be ordered by your physician.

6. Assignment to Physicians: I understand that my physician as well as other physicians who treat me or otherwise involved in my care while a patient at the hospital are not employees or agents of the hospital and the hospital is not responsible for their actions. I further understand that my physician or other physicians will send me a separate bill for their services, in addition to the hospital bill. I hereby assign to all physicians who treat me the benefits due to me for these services covering medical and/or surgical expenses. I agree that should be the amount be insufficient to cover the entire medical/surgical expense, I will be responsible to said physicians for payment of the entire bill.

7. Medicare Consent: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act (SSA) is correct. I authorize Willis-Knighton Health System (WKHS) to provide (SSA) or its intermediaries with access to my medical/hospital record for the purpose of processing the Medicare claim for this or a related Medicare claim. I further request that WKHS provide such copies thereof as may be requested. Copies may be made by WKHS or its agents or contractors providing copy service and electronic claims processing services and said third party billing agents for hospital and staff physicians involved with patient care.

8. Champus/Medicare Notice: Champus/Medicare will not pay for private rooms unless medical justified, personal convenience items, diagnostic admissions or test or hospital stays not medically necessary. My signature below acknowledges my receipt of this information regarding Champus/Medicare from the hospital on the date indicated.

9. Willis-Knighton Health System (and our Medical Staff) will use and disclose your personal health information to treat you, to receive payment for the care we provide and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website and have copies available for distribution. I acknowledge that I have received a copy of the Notice of Privacy Practices.

This form has been fully explained to me. My signature reflects my understanding of the information contained herein. I further understand and acknowledge that all references to myself as the patient shall be deemed to apply as if rewritten in their entirety to a dependent for whom I am responsible for and/or who is unable to consent on their behalf for reasons indicated below.

I acknowledge that I have been informed of my rights and obligations as a patient.

	7/14/17		7/14/17		7/14/17
Signature of Patient/Guardian	Date/Time	Guarantor	Date/Time	Witness	Date/Time
Jennifer Akach	1010		1010	J. Murray	1010
Print Name		Print Name		Print Name	

If Patient/Guarantor is unable to sign, I, _____, do hereby state that I have been given the authority to sign for

_____, either expressed or implied and that he or she is fully aware of this authority.

Signature of
Authorized Party

Authorized Party's
Relationship to the Patient

Date/Time

Witness

Date/Time

Admission Date: 07/14/17
Admission Time: 1008



AM0005



10/01/13 3Y F
Willis Jr, Fred Spence M.D.
K20033853092 07/14/17

WILLIS-KNIGHTON MEDICAL CENTER
SHREVEPORT, LA
EMERGENCY ROOM REGISTRATION INFORMATION (3008)

NAME: [REDACTED] L

ACCT. NO: K20033617935

GUARANTOR: ALEXANDER, JENNIFER

NEXT OF KIN: ALEXANDER, JENNIFER

ADDRESS: 3011 KITTY LN APT B
SHREVEPORT, LA 71107ADDRESS: 2247 LEGARDY STREET
SHREVEPORT, LA 71107

PHONE: (318)210-3821

PHONE: (318)210-3821 RELATION: PARENT

GUAR EMPLOYER: CHILD

ADDRESS:

ARRIVED FROM: C

ATTENDING PHYS: Aycock II, Richard A M.D.

PHONE:

ADMIT/OTHER PHYS:

PRIM CARE PHYS:

	NAME	POLICY #	GROUP #	BENEFIT PLAN
PRIMARY INS:	LA HLTHCARE CONN LA ME	1997286459512	[REDACTED] L	MEDICAID
SECONDARY INS:				
TERTIARY INS:				
FOURTH INS:				

ACCT NO: K20033617935

DATE: 05/06/17

UNIT#: K000629604

ROOM:

TIME: 1021

F/C: MA

STATUS: REG ER

SERV/LOC: ERS

SS#: 338-89-3614

PATIENT: [REDACTED] L

BIRTHDATE: 10/01/13

ADDRESS: 2247 LEGARDY STREET
SHREVEPORT, LA 71107

AGE: 3Y

SEX: F

PHONE: (318)210-3821

RACE: BLACK OR AFRICAN AME

RELIGION:

COUNTY: CADD0 PARISH

MARITAL STAT: SINGLE

EMPLOYER: GOD'S GIFT

PERSON TO NOTIFY: ALEXANDER, JENNIFER

ADDRESS: 2305 MARIAN PL
SHREVEPORT, LA 71109ADDRESS: 2247 LEGARDY STREET
SHREVEPORT, LA 71107

000-0000

PHONE: (318)210-3821

RELATION: PARENT

Is the Patient here for Pre-Op Testing:

Comments:

Admit Clerk: HARTJAM

Reason for Visit: PRODUCTIVE COUGH

Baby ID#:

Known Drug Allergies: NKDA

HIPPA Notice Given: Y

Date Notice Given: 08/23/14

Device Id: AMSPC5

Interpreter ID Number:

Patient Survey: N

Preferred Language: ENGLISH

Ethnicity: NHILAT

Do you have an advaced directive that you would like to present to us today? N



K20033617935

Physician Documentation

Willis Knighton South

Name: Aaliyah [REDACTED]
Age: 3 years Sex: Female DOB: 10/01/2013
Arrival Date: 05/06/2017 Time: 10:21
Bed 14

MRN: K000629604
Account#: K20033617935
Private MD: Allen, Scott

HPI:

05/06 This 3 years old African Am/Black Female presents to ED via Ambulatory with complaints of **Productive** cs9
10:51 **Cough.**
10:51 The patient presents to the emergency department with congestion, cough, with productive sputum, pulling cs9
ears. Onset: The symptoms/episode began/occurred yesterday. Associated signs and symptoms: Pertinent
positives: congestion, cough, Pertinent negatives: constipation, diarrhea, fever, nasal discharge, seizure,
shortness of breath, vomiting, wheezing. Modifying factors: The patient symptoms are alleviated by nothing,
the patient symptoms are aggravated by nothing. Treatment prior to arrival: none. The patient has
experienced a previous episode. The patient has not recently seen a physician.

Historical:

- **Allergies:** Fish; No known drug Allergies;
- **Home Meds:**
1. Albuterol Nebulizer 2.5 mg as needed
- **PMHx:** Reactive Airway Disease; Autism
- **PSHx:** None

Historical:

10:51 History obtained from mother. The history from nurses notes was reviewed and confirmed. cs9
10:55 Family history: No immediate family members are acutely ill. Immunization history: Childhood immunizations cm13
up to date. Social history: the patient is a minor.

ROS:

10:51 ROS as in the HPI, and all other systems were reviewed negative, or noncontributory, except as mentioned cs9
below. **Eyes:** Negative for injury, pain, redness, discharge, swelling, vision changes, vision loss **Neck:**
Negative for injury, pain, and swelling, **Cardiovascular:** Negative for chest pain and edema, **Abdomen/GI:**
Negative for abdominal pain, nausea, vomiting, diarrhea, constipation, hematochezia, hematemesis,
melena, anorexia, dysphagia, injury, and distension **Back:** Negative for injury, pain, deformity, and
decreased ROM **GU:** Negative for injury, bleeding, and swelling, **MS/Extremity:** Negative for injury, pain,
swelling, and decreased ROM **Skin:** Negative for injury, rash, discoloration, swelling, and lesions **Neuro:**
Negative for seizure, and altered mental status. **Constitutional:** Positive for coughing, crying, fussiness,
Negative for fever, poor PO intake, shortness of breath, vomiting. **ENT:** Positive for pulling at ears, sinus
congestion, Negative for difficulty handling secretions, difficulty swallowing, hoarseness, nasal discharge,
nose bleed, rhinorrhea. **Respiratory:** Positive for cough, Negative for hemoptysis, shortness of breath,
wheezing.

Exam:

10:51 cs9

Head/Face: Normocephalic, atraumatic.

Eyes: Pupils equal round and reactive to light, extra-ocular motions intact. Lids and lashes normal.
Conjunctiva and sclera are non-icteric and not injected. Cornea within normal limits. Periorbital areas with
no swelling, redness, or edema.

Neck: Trachea midline, no thyromegaly or masses palpated, and no cervical lymphadenopathy. Supple, full
range of motion without nuchal rigidity, or vertebral point tenderness. No Meningismus. Lymphatic No
abnormal lymphadenopathy noted by palpation in the neck or axilla

Chest/axilla: Normal symmetrical motion. No tenderness. No crepitus. No axillary masses or tenderness.

Cardiovascular: Regular rate and rhythm with a normal S1 and S2. No gallops, murmurs, or rubs. Normal
PMI, no JVD. No pulse deficits.

Respiratory: Lungs have equal breath sounds bilaterally, clear to auscultation and percussion. No rales,
rhonchi or wheezes noted. No increased work of breathing, no retractions or nasal flaring.

Abdomen/GI: Soft, non-tender with normal bowel sounds. No distension, tympany or bruits. No guarding,
rebound or rigidity. No palpable masses or evidence of tenderness with thorough palpation.

Physician Documentation Con't.**Back:** No spinal tenderness. No costovertebral tenderness. Full range of motion.**Skin:** Warm and dry with excellent turgor. capillary refill <2 seconds. No cyanosis, pallor, or rash. No evidence of cellulitis.**MS/ Extremity:** Pulses equal, no cyanosis. Neurovascular intact. Full, normal range of motion.**Neuro:** Awake or easily awakened, alert, makes good eye contact, age appropriate reflexes and responses to physical exam, good muscle tone, easily consolable.**Constitutional:** The patient appears Blood pressure, pulse, respirations and temperature noted. awake, alert, well developed, well hydrated, well nourished, non-toxic, afebrile.**ENT:** External ear(s): are unremarkable, no erythema, no swelling, no pain with movement, Ear canal(s): are normal, clear, no cerumen impaction, no erythema, no purulent discharge, no swelling, TM's: bulging, on the left, decreased mobility, is not appreciated, dullness, is not appreciated, erythema, that is moderate, on the left, Examination of the other ear shows no obvious abnormality, Nose: is normal, no drainage, no edema, no erythema, no septal hematoma, no swelling, Mouth: is normal, no gum abnormalities, no lip abnormalities, no mucosal abnormalities, no tongue abnormalities, Posterior pharynx: is normal, airway is patent, no erythema, no exudate, no peritonsillar mass, no pooling of secretions, no swelling.**Vital Signs:**

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Pain	Staff
10:29		158	26	97.2(TE)	98% on R/A	15.42 kg / 34 lbs 0 oz		jcm
10:59								cm13

10:29 crying and fighting

jcm

10:59 Patient uncooperative for vital sign reassessment

cm13

Glasgow Coma Score:

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
10:22	spontaneous(4)	incomprehensible(2)	obeys commands(6)		12	jcm

MDM:

10:46 Patient medically screened.

raa

10:54

raa

Differential diagnosis: bacterial infection, bronchitis, pneumonia URI, viral Infection. I personally performed the services described in this documentation as scribed in my presence, and it is both accurate and complete.**Data reviewed:** vital signs, nurses notes, and as a result, I will discharge patient, Give prescription at discharge.**Counseling:** I had a detailed discussion with the patient and/or guardian regarding: the historical points, exam findings, and any diagnostic results supporting the discharge/admit diagnosis, the need for outpatient follow up, to return to the emergency department if symptoms worsen or persist or if there are any questions or concerns that arise at home.**ED course:** MDM- ed eval consistent with benign uri sxs with otitis media, do not suspect pneumonia, influenza, nor reactive airway.**Disposition:**

10:53 This chart was scribed by Scott, Christian, Scribe. in the presence of Richard Aycock II MD.

cs9

10:54 Electronically signed by: R Aycock MD.

raa

Disposition:**05/06/17 10:49 Discharged to Home/Self Care. Impression: Otitis Media, Upper Respiratory Infection (URI).**

- Condition is Stable.

Name: Aaliyah [REDACTED]

MRN: K000629604

Account#: K20033617935

Print Time: 5/7/2017 13:01:27

Page 2 of 3

Physician Documentation Con't.

- Discharge Instructions: Ear - Middle, Infection (Otitis Media), Child, Upper Respiratory Infection (URI), Child.
- Prescriptions for
 - Amoxicillin 400 mg/5 mL Oral Suspension for Reconstitution
 - take 9 milliliter by ORAL route every 12 hours for 10 days; 180 milliliter.
 - Benadryl 12.5 mg/5 mL Oral Elixir
 - take 8 milliliter by ORAL route every 6 hours (16 kg); 160 milliliter.
- Follow up: MLK area Clinic Willis-Knighton; When: 2 days; Reason: Recheck today's complaints, Or sooner if you get worse.
- Problem is new.
- Symptoms have improved.
- Notes:
 - tylenol and motrin for fever. return to er if symptoms no better in 2 days.

Signatures:

Aycock II, Richard, MD
McDaniel, Crystal, RN

MD raa
RN cm13

Mathews, Janet, RN
Scott, Christian, Scribe

RN jcm
Scribe cs9

Nurse's Notes

Name: Aaliyah
Age: 3 years Sex: Female DOB: 10/01/2013
Arrival Date: 05/06/2017 Time: 10:21
Bed 14

Willis Knighton South

MRN: K000629604
Account#: K20033617935
Private MD: Allen, Scott

Presentation:

05/06 Method of Arrival: Ambulatory. jcm
10:22 Preferred language for medical communication is English. Presenting complaint: Mother states: Productive cough and fever since yesterday and pulling ears. Person Transporting: Parent. Transition of care: patient was not received from another setting of care. jcm
10:31 Acuity: 4 - Semi-Urgent. jcm

Triage Assessment:

10:22 **General:** Appears in no apparent distress, well developed, well nourished, Behavior is restless, fussy, uncooperative, mobility; ambulates without assistance Reports fever for 12-24 hours. **Pain:** level that is acceptable is 0 out of 10 on a pain scale. **FACES** pain scale score is 0 out of 10. jcm

Historical:

- **Allergies:** Fish; No known drug Allergies;
- **Home Meds:**
 1. Albuterol Nebulizer 2.5 mg as needed
- **PMHx:** Reactive Airway Disease; Autism
- **PSHx:** None

Historical:

10:51 History obtained from mother. The history from nurses notes was reviewed and confirmed. cs9
10:55 Family history: No immediate family members are acutely ill. Immunization history: Childhood immunizations up to date. cm13
Social history: the patient is a minor.

Screening:

10:22 **Abuse screen:** there are no obvious signs of child abuse. jcm
Patient fall risk assessment; risks identified; None.
Learning Barriers: age barrier identified, the patient has a cognitive barrier to learning caregiver ready and willing to learn.
Pedi Fall Risk None Identified.
Exposure risk/Travel Screening: None identified.

Assessment:

10:55 **Pain:** level that is acceptable is 0 out of 10 on a pain scale. Pain assessment behavioral pain scale score is 6 out of 10. **General:** Appears uncomfortable, Behavior is crying, fussy, Reports fever for 1-2 days. **Neuro:** Level of Consciousness is alert, awake. **EENT:** Parent/caregiver reports the patient having nasal congestion nasal discharge for 2 day(s). **Respiratory:** Respiratory effort is even, unlabored, Respiratory pattern is regular, symmetrical, Airway is patent Parent/caregiver reports the patient having cough that is productive, for 2 day(s). **Dermatologic:** Skin is pink, warm & dry. **Musculoskeletal:** No deficits noted. cm13
10:55 **General:** Mother reports that patient is non verbal. cm13

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Pain	Staff
10:29		158	26	97.2(TE)	98% on R/A	15.42 kg / 34 lbs 0 oz		jcm
10:59								cm13

10:29 crying and fighting jcm
10:59 Patient uncooperative for vital sign reassessment cm13

Vitals:

10:29 Acuity: 4 - Semi-Urgent. jcm
10:55 Body Mass Index = 16.55. cm13

Glasgow Coma Score:

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Nurse's Notes Con't

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
10:22	spontaneous(4)	incomprehensible(2)	obeys commands(6)		12	jcm

ED Course:

10:21 Patient arrived in ED. ms2
 10:21 Patient moved to KIOSK. ms2
 10:31 Triage completed. jcm
 10:31 Patient moved to Waiting. jcm
 10:37 Patient moved to 14. rbp
 10:43 Aycock II, Richard, MD is Attending Physician. raa
 10:49 Willis-Knighton, MLK area Clinic is Referral Physician. raa
 10:55 Patient/caregiver encouraged to voice any concerns. Side rails up X 1. Call light in reach. Instructed to call for assist when getting up, verbalized understanding. Adult with patient. Child being held by parent. Door closed. cm13
 10:57 Allen, Scott is Private Physician. cm13
 10:59 McDaniel, Crystal, RN is Primary Nurse. cm13
 10:59 No procedures done that require assistance. cm13

Administered Medications:

No medications were administered

Outcome:

10:49 Discharge ordered by MD. raa
 10:59 Discharged to home, ambulatory, with family. Discharge instructions given to Mother Instructed on discharge instructions, follow up and referral plans, medication usage, fever management, Demonstrated understanding of instructions, medications, Prescriptions given; 2, No questions or concerns expressed to me at discharge. No belongings were removed by WK staff. **Medication reconciliation form provided.**
Med Effects: Patient recieved no medications during this visit. **Oxygen use:** Oxygen use not applicable.
 11:01 Electronic medical record closed. cm13

Signatures:

Aycock II, Richard, MD	MD	raa	Mathews, Janet, RN	RN	jcm
Pabalan, Renaida, RN	RN	rbp	Scriptuser, MEDHOST		ms2
McDaniel, Crystal, RN	RN	cm13	Scott, Christian, Scribe	Scribe	cs9

Corrections:

10:32 ~~10:22~~ Presenting complaint: Mother states: Productive cough and fever since yesterday jcm jcm

RUN DATE: 05/06/17
RUN TIME: 1032
RUN USER: HARTJ.AM

Willis Knighton with *ADMISSION
INTERDISCIPLINARY ALLERGY SOURCE DOCUMENT

PAGE 1

Name: [REDACTED] L DOB: 10/01/13 Age: 3Y 07M
Rm/Bd: Serv/Locn: ERS Status: ER Sex: F
Unit#: K000629604 Account#: K20033617935 EPI#: 000000001116206

Last Update/
Acknowledgement:

Interdisciplinary Assessment (Free Text), historical data:

Allergy1-Med/Contact: NKDA	11/04/16 - 2201
Allergy2-Med/Contact: NKDA	11/04/16 - 2201
Food Allergies-Intol: NKFA	11/04/16 - 2201
Latex Allergy (Y/N): N	11/04/16 - 2201

Pharmacy Allergy List (Coded Allergies), historical data:
(Duplicate names represent coding within (3) categories:
Ingredient, Generic and Class allergy codes.)

11/06/16

NO KNOWN DRUG ALLERGIES, NO KNOWN FOOD ALLERGIES, NO KNOWN LATEX ALLERGY



[REDACTED] L
10/01/13 3Y 07M
Aycock II, Richard
K20033617935 05/06/17

Interdisciplinary Allergy Source Document is a Permanent Part of
the Patient's Medical Record

Willis Knighton South and Center for Women's Health

Willis Knighton South2510 Bert Kouns Industrial Loop
Shreveport, LA 71118
318-212-5500

Discharge Instructions for: [REDACTED] L

Arrival Date: 05/06/17 10:21

Care Complete Time: 05/06/17 10:49

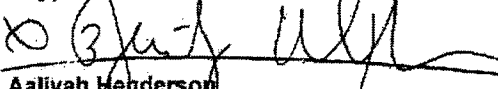
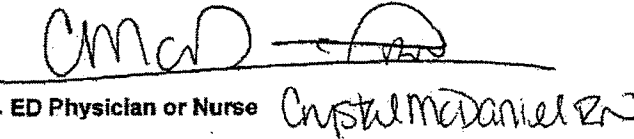
Thank you for choosing **Willis Knighton South** for your care today. The examination and treatment you have received in the Emergency Department today have been rendered on an emergency basis only and are not intended to be a substitute for an effort to provide complete medical care. You should contact your follow-up physician as it is important that you let him or her check you and report any new or remaining problems since it is impossible to recognize and treat all elements of an injury or illness in a single emergency care center visit.

Care provided by: Aycock II, Richard, MD

Diagnosis: Otitis Media; Upper Respiratory Infection (URI)

DISCHARGE INSTRUCTIONS	FORMS
Ear - Middle, Infection (Otitis Media), Child Upper Respiratory Infection (URI), Child	None
FOLLOW UP INSTRUCTIONS	PRESCRIPTIONS
Willis-Knighton, MLK area Clinic (Family Medicine) When: 2 days; Reason: Recheck today's complaints, Or sooner if you get worse	Amoxicillin Benadryl
SPECIAL NOTES	
tylenol and motrin for fever. return to er if symptoms no better in 2 days.	

I hereby acknowledge that I have received and understand the above instructions and prescriptions (if any).


Aaliyah Henderson
MRN # K000629604


ED Physician or Nurse

X-RAYS and LAB TESTS:

If you had x-rays today they were read by the emergency physician. Your x-rays will also be read by a radiologist within 24 hours. If you had a culture done it will take 24 to 72 hours to get the results. If there is a change in the x-ray diagnosis or a positive culture, we will contact you. Please verify your current phone number prior to discharge at the check out desk.

MEDICATIONS:

If you received a prescription for medication(s) today, it is important that when you fill this you let the pharmacist know all the other medications that you are on and any allergies you might have. It is also important that you notify your follow-up physician of all your medications including the prescriptions you may receive today.

Chart Copy



HENDERSON [REDACTED] L
10/01/15 3Y 07M
Aycock II, Richard
X2003363935 05/06/17

FOLLOW UP INSTRUCTIONS

Willis-Knighton, MLK area Clinic (Family Medicine)

4700 Shreveport Blanchard Hwy

Shreveport, LA 71107

318-221-1001

When: 2 days

Reason: Recheck today's complaints, Or sooner if you get worse

PRESCRIPTIONS

Amoxicillin 400 mg/5 mL Oral Suspension for Reconstitution

Take 9 milliliter by ORAL route every 12 hours for 10 days; 180 milliliter

Benadryl 12.5 mg/5 mL Oral Elixir

Take 8 milliliter by ORAL route every 6 hours (16 kg); 160 milliliter

TESTS AND PROCEDURES

Labs

None

Rad

None

Procedures

None

Other

None



AYCOCK, ALIYAH L
10/01/13 3Y 07M
Aycock II, Richard
K20033617935

05/06/17



ASSIGNMENT OF BENEFITS

1. Hospital Care Consent: I/we consent to hospital services, treatment and diagnostic procedures by the hospital as may be deemed necessary or advisable by my physician and/or consultants selected by my physician. The consent to hospital care includes permission for x-ray examinations, laboratory procedures, I.V. treatments, hepatitis test administration of blood and blood products, injections, medications, recording, filming or video monitoring for internal purposes only, and hospital services rendered the patient under the general and special instruction of doctors. The patient acknowledges responsibility for any or all of these procedures. It is the hospital policy that the patient has the opportunity to discuss surgery and procedures with the patient's doctor before hand. The patient has the right to consent to surgery and procedures. Except in emergencies or unusual circumstances, the hospital does not allow its facilities to be used without this discussion and patient's consent. I voluntarily give my consent to hospital care and accept the condition of hospitalization listed.

2. Authorizations for Release of Information: The employees and agents of this hospital and copy services and electronic claims processing services under contract with this hospital and any third party billing agents for this hospital or any of its staff physicians involved with patient care are given permission to release any and all information relating to the patient, including but not limited to the medical record of the patient's hospitalization, to another healthcare provider if the patient was transferred to that facility from this hospital and to any and all insurance companies or other third-party paying or obligated to pay, in whole or in part, the charges incurred by the patient in this hospital; and they are also given permission to release the above described information to any agent or firm working for or with the above described insurance companies or other third-party payors for the purpose of performing pre-certification, concurrent and/or retrospective review and/or other utilization review of any kind.

3. Valuables: I understand and acknowledge that the hospital assumes no responsibility for personal possessions including cash, jewelry, bridgework, eyeglasses or any other personal possession which I choose to keep in my room. I have been advised that such valuables should be placed in the care of my family or deposited in the hospital vault located in the Business Office.

4. Safety Code for Hospital: Safety Codes for hospitals issued by the National Fire Protection Association prevent the use in the hospital of any electrical equipment or accessories until they have been safety checked by the hospital's electrical engineer. Exceptions to this rule are hair and blow dryers, curling irons, hot rollers, radios, clocks, electric razors, shavers, contact lens sterilizers, electric toothbrushes and calculators.

5. Payment Guaranty and Assignment of Insurance Benefits: I, the undersigned patient, guardian, and/or guarantor (hereinafter "Debtor") hereby promise to pay in full Willis-Knighton Health System (WKHS) customary charges for the goods and services rendered to the patient identified on the reverse side hereof during this period of hospitalization (hereinafter "Indebtedness"). Debtor acknowledges and agrees that, unless waived in full by WKHS as set forth below, the Indebtedness accruing during this hospitalization is due and payable in such amounts and at such times during this hospitalization as WKHS may, in its sole discretion, determine, that the entire Indebtedness is due and payable in full at discharge. I acknowledge that, upon proof of acceptable insurance coverage, WKHS, in its sole discretion, may reduce the amount of indebtedness due and payable during this hospitalizations and the balance due at discharge. In such event, I understand that all deductibles, co-insurance, non-covered charges and other items not paid by insurance or other third-party payors shall be due and payable during this period of hospitalization and upon discharge as set forth hereinabove. I acknowledge and agree that in the event that WKHS, in its sole discretion, accepts proof of insurance coverage, claims for payment for benefits will be filed on behalf of the Debtor and/or the insured and that these benefits will be considered by WKHS in determining the amounts due as set forth hereinabove. I understand and agree that WKHS will accept payments from third-party payors and insurers on behalf of the Debtor and apply such payment to the indebtedness to the extent that they are received. I acknowledge and agree that the filing of such insurance and other third-party claims is performed as a service by WKHS and in no way relieves me of the obligation to pay the Indebtedness as agreed herein above.

Patient hereby appoints WKMC as Patient's authorized representative to file any necessary claim appeal(s) on Patient's behalf. In consideration for this appointment, WKMC agrees only to collect only applicable copayments, deductibles, and coinsurance for covered benefits from the Patient and waives any right to collect any other payments related to those covered benefits from the Patient.

Debtor hereby absolutely assigns to WKHS all insurance benefits on all policies of insurance under which Debtor is an insured, whether hospital, medical, liability or other insurance, and also hereby absolutely assigns to WKHS the proceeds of any judgment or settlement of any claim against any third party and any and all other amounts which may be determined in any manner to be payable to Debtor in connection with any injury suffered by the patient which gives rise to the Indebtedness incurred during this period of treatment. I hereby authorize WKHS to obtain any and all information related to such injuries, including, but not limited to, accident reports and agree to cooperate with WKHS in connection with the procurement of any information or documents WKHS deems in its sole discretion, necessary or appropriate in connection with the assignment made pursuant to this paragraph. I hereby authorize and direct that all such payments and proceeds shall be made directly to WKHS under the terms of this assignment. Any receipts from WKHS shall be applied towards Indebtedness but such application shall not relieve the Debtor from the Debtor's obligation to pay any remaining portion to the Indebtedness. Debtor acknowledges and agrees that, to the extent that the Indebtedness has not been satisfied by such receipts, that portion of the Indebtedness for which payment has been deferred pursuant to the preceding paragraph shall be due and payable in full on the thirtieth day following the date of service. In the event that WKHS receives proceeds and/or payments in excess of the Indebtedness, WKHS may apply such excess payment to any outstanding Indebtedness of Debtor to WKHS arising out of any other period(s) of treatment as well as any attorneys' fees and expenses for which Debtor may be liable hereunder. In the event that all Indebtedness has been paid

Admission Date: 05/06/17

Admission Time: 1021



AM0005



10/01/13 3Y F
Aycock II, Richard A M.D.
K20033617935 05/06/17



ASSIGNMENT OF BENEFITS

in full, then WKHS will refund the Debtor any such excess payment. Notwithstanding anything herein to the contrary, the assignments made hereby shall remain in full force and effect until the entire Indebtedness and any and all attorneys' fees and expenses for which Debtor may be liable have been paid in full. In the event that the Indebtedness is not paid when and as due as determined by WKHS hereunder, and the Indebtedness is placed in the hands of an attorney for purposes of collection, Debtor agrees to pay reasonable attorneys' fees, which are hereby acknowledged to be one-third (1/3) of the amount of the Indebtedness at the time the matter is placed in the hands of an attorney, plus any and all court costs and other expenses incurred in connection with the collection of the Indebtedness.

Financial assistance is available to all patients who meet the requirements of our charity care policy. Patients are encouraged to contact the Business Office if they have any concerns or need assistance in paying their bills. Our charity care policy is limited to hospital charges and does not include physician, anesthesiologist or professional charges that are not billed by the hospital. In addition, financial assistance is not offered for cosmetic, elective, experimental or other treatments and all hospital services must be ordered by your physician.

6. Assignment to Physicians: I understand that my physician as well as other physicians who treat me or otherwise involved in my care while a patient at the hospital are not employees or agents of the hospital and the hospital is not responsible for their actions. I further understand that my physician or other physicians will send me a separate bill for their services, in addition to the hospital bill. I hereby assign to all physicians who treat me the benefits due to me for these services covering medical and/or surgical expenses. I agree that should the amount be insufficient to cover the entire medical/surgical expense, I will be responsible to said physicians for payment of the entire bill.

7. Medicare Consent: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act (SSA) is correct. I authorize Willis-Knighton Health System (WKHS) to provide (SSA) or its intermediaries with access to my medical/hospital record for the purpose of processing the Medicare claim for this or a related Medicare claim. I further request that WKHS provide such copies thereof as may be requested. Copies may be made by WKHS or its agents or contractors providing copy service and electronic claims processing services and said third party billing agents for hospital and staff physicians involved with patient care.

8. Champus/Medicare Notice: Champus/Medicare will not pay for private rooms unless medical justified, personal convenience items, diagnostic admissions or test or hospital stays not medically necessary. My signature below acknowledges my receipt of this information regarding Champus/Medicare from the hospital on the date indicated.

9. Willis-Knighton Health System (and our Medical Staff) will use and disclose your personal health information to treat you, to receive payment for the care we provide and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website and have copies available for distribution. I acknowledge that I have received a copy of the Notice of Privacy Practices.

This form has been fully explained to me. My signature reflects my understanding of the information contained herein. I further understand and acknowledge that all references to myself as the patient shall be deemed to apply as if rewritten in their entirety to a dependent for whom I am responsible for and/or who is unable to consent on their behalf for reasons indicated below.

I acknowledge that I have been informed of my rights and obligations as a patient.

Signature of Patient/Guardian	Guarantor	Witness
5/6/17	5/6/17	5/6/17
Date/Time	Date/Time	Date/Time
Print Name	Print Name	Print Name

If Patient/Guarantor is unable to sign, I, _____, do hereby state that I have been given the authority to sign for

_____, either expressed or implied and that he or she is fully aware of this authority.

Signature of Authorized Party	Authorized Party's Relationship to the Patient	Date/Time	Witness	Date/Time
----------------------------------	---	-----------	---------	-----------

Admission Date: 05/06/17
Admission Time: 1021



AM0005



10/01/13 3Y F
Aycock II, Richard A.M.D.
K20033617935 05/06/17

WILLIS-KNIGHTON MEDICAL CENTER

SHREVEPORT, LA

EMERGENCY ROOM REGISTRATION INFORMATION (1008)

NAME: [REDACTED] L

ACCT. NO: K20033531813

GUARANTOR: ALEXANDER, JENNIFER

NEXT OF KIN: ALEXANDER, JENNIFER

ADDRESS: 3011 KITTY LN APT B
SHREVEPORT, LA 71107ADDRESS: 2247 LEGARDY STREET
SHREVEPORT, LA 71107

PHONE: (318) 210-3821

PHONE: (318) 210-3821 RELATION: PARENT

GUAR EMPLOYER: CHILD

ADDRESS:

ARRIVED FROM: C.

ATTENDING PHYS: Haynes, Andrew T M.D.

PHONE:

ADMIT/OTHER PHYS:

PRIM CARE PHYS:

	NAME	POLICY #	GROUP #	BENEFIT PLAN
PRIMARY INS:	LA HLTHCARE CONN LA ME	1997286459512	[REDACTED]	MEDICAID
SECONDARY INS:				
TERTIARY INS:				
FOURTH INS:				

ACCT NO: K20033531813

DATE: 04/12/17

UNIT#: K000629604

ROOM:

TIME: 1708

F/C: MA

STATUS: REG ER

SERV/LOC: ERS

SS#: 338-89-3614

PATIENT: [REDACTED] L

BIRTHDATE: 10/01/13

ADDRESS: 2247 LEGARDY STREET
SHREVEPORT, LA 71107

AGE: 3Y

SEX: F

PHONE: (318) 210-3821

RACE: BLACK OR AFRICAN AME

RELIGION:

COUNTY: CADD0 PARISH

MARITAL STAT: SINGLE

EMPLOYER: GOD'S GIFT

PERSON TO NOTIFY: ALEXANDER, JENNIFER

ADDRESS: 2305 MARIAN PL
SHREVEPORT, LA 71109
000-0000ADDRESS: 2247 LEGARDY STREET
SHREVEPORT, LA 71107

PHONE: (318) 210-3821

RELATION: PARENT

Is the Patient here for Pre-Op Testing:

Comments:

Admit Clerk: SAFFED1.A

Reason for Visit: BREATHING DIFFICULTY FEVER

Baby ID#:

Known Drug Allergies: NKDA

HIPPA Notice Given: Y

Date Notice Given: 09/23/14

Device Id: AMSPC6

Interpreter ID Number:

Patient Survey: U

Preferred Language: ENGLISH

Ethnicity: NHILAT

Do you have an advaced directive that you would like to present to us today? U



K20033531813

L #

1909 7

Physician Documentation

Willis Knighton South

Name: Aaliyah [REDACTED]
Age: 3 years Sex: Female DOB: 10/01/2013
Arrival Date: 04/12/2017 Time: 17:08
Bed Post IM1

MRN: K000629604
Account#: K20033531813
Private MD: LSU/UH, KidMed clinic

HPI:

04/12 This 3 years old African Am/Black Female presents to ED via Carried with complaints of **Fever, Breathing** stj
17:49 **Difficulty**.
17:49 The patient presents to the emergency department with congestion, cough, fever, wheezing. Onset: The stj
symptoms/episode began/occurred today. Associated signs and symptoms: The patient has no apparent
associated signs or symptoms. Modifying factors: The patient symptoms are alleviated by nothing, the
patient symptoms are aggravated by nothing. Treatment prior to arrival: none. The patient has not
experienced similar symptoms in the past, but does have hx of wheezing with Asthma.
17:51 The patient has not recently seen a physician. stj

Historical:

- **Allergies:** No known drug Allergies;
- **Home Meds:**
 1. Albuterol Nebulizer 2.5 mg as needed
- **PMHx:** Autism; Reactive Airway Disease
- **PSHx:** None

Historical:

17:51 History obtained from mother. The history from nurses notes was reviewed and confirmed. stj

ROS:

17:51 ROS as in the HPI, and all other systems were reviewed negative, or noncontributory, except as mentioned. stj
below. **Eyes:** Negative for injury, pain, redness, and discharge **Neck:** Negative for injury, pain, and swelling,
Cardiovascular: Negative for chest pain, palpitations, and edema, **Abdomen/GI:** Negative for abdominal
pain, nausea, vomiting, diarrhea, and constipation, **Back:** Negative for injury and pain, **GU:** Negative for
injury, bleeding, discharge, and swelling, **MS/Extremity:** Negative for injury and deformity, **Skin:** Negative
for injury, rash, and discoloration, **Neuro:** Negative for headache, weakness, numbness, tingling, and
seizure. **Constitutional:** Positive for coughing, fever, Negative for shortness of breath, vomiting. **ENT:**
Positive for rhinorrhea, sinus congestion, Negative for difficulty handling secretions, difficulty swallowing.
Respiratory: Positive for cough, wheezing, Negative for dyspnea on exertion, hemoptysis, shortness of
breath.

Exam:

17:51 stj

Head/Face: Normocephalic, atraumatic.

Eyes: Pupils equal round and reactive to light, extra-ocular motions intact. Lids and lashes normal.
Conjunctiva and sclera are non-icteric and not injected. Cornea within normal limits. Periorbital areas with
no swelling, redness, or edema.

Neck: Trachea midline, no thyromegaly or masses palpated, and no cervical lymphadenopathy. Supple, full
range of motion without nuchal rigidity, or vertebral point tenderness. No Meningismus. Lymphatic No
abnormal lymphadenopathy noted by palpation in the neck or axilla

Chest/axilla: Normal chest wall appearance and motion. No tenderness, no deformity, no crepitus, no
axillary masses or tenderness, and no lesions appreciated.

Cardiovascular: Regular rate and rhythm with a normal S1 and S2. No gallops, murmurs, or rubs. Normal
PMI, no JVD. No pulse deficits.

Abdomen/GI: Soft, nontender, nondistended, no mass, no hepatosplenomegaly. No rebound or guarding.
Bowel sounds present all quadrants. No hernia noted.

Back: Normal inspection with no obvious deformity. No spinal or CVA tenderness. Normal ROM without
pain.

Skin: Warm and dry with excellent turgor. capillary refill <2 seconds. No cyanosis, pallor, rash, cellulitis, or
edema.

MS/ Extremity: Pulses equal, no clubbing, cyanosis, or edema. Neurovascular intact. Full, normal range of

Physician Documentation Con't.

motion without pain.

Neuro: Awake, and alert. Good muscle tone. Moves all extremities well. Sensory grossly intact.

Constitutional: The patient appears Blood pressure, pulse, respirations and temperature noted. awake, alert, well developed, non-toxic, febrile, restless, crying.

ENT: External ear(s): are unremarkable, no acute changes, Ear canal(s): are normal, no acute changes, TM's: dullness, bilaterally, erythema, bilaterally, Nose: nasal drainage, that is clear, Mouth: is normal, Oral mucosa: moist, Posterior pharynx: is normal, airway is patent, no erythema, no exudate, no peritonsillar mass, no pooling of secretions.

Respiratory: the patient does not display signs of respiratory distress, Respirations: normal, no use of accessory muscles, no evidence of nasal flaring, no retractions, no tachypnea, Breath sounds: rales, are not appreciated, rhonchi, are not appreciated, crackles, are not appreciated, wheezing, that is moderate, is heard diffusely.

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Pain	Staff
17:11		174	36	102.2(R)	95%	14.97 kg / 33 lbs 0 oz (M)		fmb
18:55		170		100.0	96% on R/A			sd4
19:16		164	28	99.0(A)	98%		0/10	spm

Glasgow Coma Score:

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
17:11	spontaneous(4)	coos, babbles(5)	spontaneous(6)		15	fmb

MDM:

17:51 Patient medically screened.

ah

17:51

stj

Data reviewed: vital signs, nurses notes, radiologic studies, and as a result, I will discharge patient, Give prescription at discharge.

Counseling: I had a detailed discussion with the patient and/or guardian regarding: the historical points, exam findings, and any diagnostic results supporting the discharge/admit diagnosis, lab results, the need for outpatient follow up, to return to the emergency department if symptoms worsen or persist or if there are any questions or concerns that arise at home.

19:07 I personally performed the services described in this documentation as scribed in my presence, and it is both accurate and complete.

ah

ED course: pt looks good in ED. Non ill appearing. wheeze resolved. Will dc with meds and f/u.

Order	Status	Time	By	For
Motrin Suspension 1 dose PO once; Per Pedi Fever Standing Orders	Ordered	04/12/17 17:18	fmb	dre
	Administered	04/12/17 17:18	fmb	
Notes:	Order Method: Verbal - Read back			
	Sign off: Haynes, Andrew, MD 04/12/17 17:51			
04/12/17 17:18	Administration: Motrin Suspension 1 dose PO			fmb
04/12/17 19:18	Follow Up: Response: Temperature is decreased			spm
Order	Status	Time	By	For
COLLECT SWAB	Ordered	04/12/17 17:23	ah	ah
	Completed	04/12/17 17:36	Mathews, Janet, RN	
Notes:	Order Method: Electronic			

Name: Aaliyah [REDACTED]

MRN: K000629604

Account#: K20033531813

Print Time: 4/13/2017 21:21:47

Page 2 of 4

Physician Documentation Con't.

Order	Status	Time	By	For
Influenza by PCR	Ordered	04/12/17 17:23	ah	ah
	Reviewed	04/12/17 18:49	Haynes, Andrew, MD	
Notes:	Order Method: Electronic			
Interpretation: Normal.				
Ordering Location: ERSPC100.1				
Order	Status	Time	By	For
Call X-Ray Tech	Ordered	04/12/17 17:24	ah	ah
	Completed	04/12/17 17:26	Clinger, Steven, RN	
Notes:	Order Method: Electronic			
Order	Status	Time	By	For
Chest Xray Portable 1 View	Ordered	04/12/17 17:24	ah	ah
	Reviewed	04/12/17 17:51	Haynes, Andrew, MD	
Notes: Bed Name: 14	Order Method: Electronic			
Interpretation: Normal: Normal.				
SPECIFIC TIME TO BE DONE: (OERDSPECTI): STAT				
ER EXAM ROOM/BED: (OERDERRMBD): 14				
Is the patient able to bear weight? (OERDBEARWT):				
Is the patient at risk for falls? (OERDFALLS):				
MODE OF TRANSPORTATION : (OERDTRANS): STRETCHER				
O2: (OEADO2): No				
REASON FOR EXAM: (OERDEXAM): Fever				
Order	Status	Time	By	For
DuoNeb 1 unit dose Inhalation once	Ordered	04/12/17 17:51	ah	ah
	Administered	04/12/17 18:02	jcm	
Notes:	Order Method: Electronic			
04/12/17 18:02 Administration: DuoNeb 1 unit dose Inhalation jcm				
04/12/17 18:47 Follow Up: Response: No Adverse Reaction; Respiratory status improved jcm				
Order	Status	Time	By	For
Orapred 2 tsp PO once	Ordered	04/12/17 17:51	ah	ah
	Administered	04/12/17 18:02	jcm	
Notes:	Order Method: Electronic			
04/12/17 18:02 Administration: Orapred 2 tsp PO jcm				
04/12/17 18:47 Follow Up: Response: No Adverse Reaction jcm				

Order Signatures:

Haynes, Andrew, MD

MD ah

Easterling, David, MD

MD dre

Name: Aaliyah [REDACTED]

MRN: K000629604
Account#: K20033531813

Physician Documentation Con't.

Baldrige, Mercedes, RN RN fmb

Disposition:

17:51 This chart was scribed by Jorden, Samuel, Scribe, in the presence of Andrew Haynes MD.

stj

19:07 Electronically signed by: Andrew Haynes M.D. Disposition.

ah

Disposition:

04/12/17 19:09 Discharged to Home/Self Care. Impression: Upper Respiratory Infection (URI), Asthma with Acute Exacerbation.

- Condition is Stable.
- Discharge Instructions: Asthma, Childhood, Fever, Child (with Dosage Charts), Upper Respiratory Infection (URI), Child.
- Prescriptions for
 - Orapred 15 mg/5 mL Oral Solution
 - take 8 milliliter by ORAL route once daily for 5 days; 40 milliliter.
 - Amoxicillin 400 mg/5 mL Oral Suspension for Reconstitution
 - take 7 milliliter by ORAL route every 12 hours for 10 days; 140 milliliter.
- Follow up: KidMed clinic LSU/UH; When: 2 days.
- Problem is new.
- Symptoms have improved.

Signatures:

Dispatcher MedHost	EDMS	Clinger, Steven, RN	RN	smc
Haynes, Andrew, MD	MD ah	Mathews, Janet, RN	RN	jcm
Moore, Susan, RN	RN spm	Baldrige, Mercedes, RN	RN	fmb
Jorden, Samuel, Scribe	Scribe stj			

Corrections:

18:17 ~~17:51 Normal~~

ah ah

Nurse's Notes

Name: Aaliyah
Age: 3 years Sex: Female DOB: 10/01/2013
Arrival Date: 04/12/2017 Time: 17:08
Bed Post IM1

Willis Knighton South

MRN: K000629604
Account#: K20033531813
Private MD: LSU/UH, KidMed clinic

Presentation:

04/12 Method of Arrival: Carried. fmb
17:11 Preferred language for medical communication is English. Presenting complaint: Patient states: "She has been having fever and now she is wheezing". Person Transporting: Parent. Transition of care: patient was not received from another setting of care. Care prior to arrival: Medications: Tylenol at 1200. fmb
17:16 Acuity: 4 - Semi-Urgent. fmb

Triage Assessment:

17:11 **General:** Appears well developed, well nourished, Behavior is inappropriate for age. **Pain:** Faces, Legs, Activity, Cry, Consolability scale score is 0 out of 10. fmb

Historical:

- **Allergies:** No known drug Allergies;
- **Home Meds:**
 1. Albuterol Nebulizer 2.5 mg as needed
- **PMHx:** Autism; Reactive Airway Disease
- **PSHx:** None

Historical:

17:51 History obtained from mother. The history from stj nurses notes was reviewed and confirmed.

Screening:

17:11 **Abuse screen:** fmb
Denies threats or abuse. Denies injuries from another, there are no obvious signs of child abuse.
Patient fall risk assessment;
risks identified; None.
Learning Barriers:
No barriers to teaching and learning identified. caregiver ready and willing to learn.
Pedi Fall Risk
None Identified.
Exposure risk/Travel Screening:
None identified.

Assessment:

17:29 **Pain:** level that is acceptable is 0 out of 10 on a pain scale. Faces, Legs, Activity, Cry, Consolability scale score is 6 out of 10. **General:** Appears in no apparent distress, well developed, well nourished, well groomed, Behavior is agitated, anxious, mobility; ambulates without assistance. **Neuro:** Level of Consciousness is alert, awake, Moves all extremities. Speech nonverbal. **EENT:** Parent/caregiver reports the patient having nasal discharge. **Cardiovascular:** Capillary refill < 3 seconds is brisk in bilateral fingers. **Respiratory:** Respiratory effort is even, unlabored, Respiratory pattern is regular, symmetrical, Parent/caregiver reports the patient having cough that is. **Dermatologic:** Skin is healthy with good turgor, Skin is dry, Skin is normal, Skin temperature is warm. **Musculoskeletal:** No deficits noted. dgg
18:55 **General:** Appears in no apparent distress, well developed, well nourished, Behavior is crying, fussy, mobility; ambulates without assistance. **Respiratory:** Respiratory effort is even, unlabored, Respiratory pattern is regular, symmetrical, Airway is patent. sd4

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Pain	Staff
17:11		174	36	102.2(R)	95%	14.97 kg / 33 lbs 0 oz (M)		fmb
18:55		170		100.0	96% on R/A			sd4
19:16		164	28	99.0(A)	98%		0/10	spm

Vitals:

17:11 Acuity: 4 - Semi-Urgent. fmb
19:17 Body Mass Index = spm

Nurse's Notes Con't**Glasgow Coma Score:**

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
17:11	spontaneous(4)	coos, babbles(5)	spontaneous(6)		15	fmb

ED Course:

17:08 Patient arrived in ED. ms2
 17:08 Patient moved to KIOSK. ms2
 17:11 LSU/UH, KidMed clinic is Private Physician. fmb
 17:19 Patient moved to Waiting. fmb
 17:22 Patient moved to 14. dgg
 17:23 Haynes, Andrew, MD is Attending Physician. ah
 17:27 Patient moved to Radiology. aw7
 17:27 Chest Xray Portable 1 View Sent. aw7
 17:31 Patient/caregiver encouraged to voice any concerns. Side rails up X 1. Bed in low position. Call light in reach. Instructed to call for assist when getting up, verbalized understanding. Patient has correct armband on for positive identification. Adult with patient. dgg
 17:34 Patient moved to 14. aw7
 17:35 Mathews, Janet, RN is Primary Nurse. jcm
 17:36 Influenza culture sent to lab. jcm
 17:36 No procedures done that require assistance. jcm
 18:51 Report given to Syndee, RN, using the SBAR communication method. jcm
 18:55 David, Syndee, RN is Primary Nurse. sd4
 18:56 Appears tearful. Awaiting disposition. sd4
 19:09 LSU/UH, KidMed clinic is Referral Physician. ah
 19:17 Patient moved to Post IM1. aca

Administered Medications:

Time	Drug & Dose	Route	Rate	Duration	Site	Delivery	Staff
17:18	Motrin Suspension 1 dose	PO					fmb
19:18	Follow up: Response: Temperature is decreased						spm
18:02	DuoNeb 1 unit dose	Inhalation					jcm
18:47	Follow up: Response: No Adverse Reaction; Respiratory status improved						jcm
18:02	Orapred 2 tsp	PO					jcm
18:47	Follow up: Response: No Adverse Reaction						jcm

Outcome:

19:09 Discharge ordered by MD. ah
 19:16 Discharged to home, ambulatory, with family. Discharge instructions given to Mother Instructed on discharge instructions, follow up and referral plans, medication usage, fever management, Demonstrated understanding of instructions, Prescriptions given; 2, No questions or concerns expressed to me at discharge. **Medication reconcilliation form provided. Med Effects:** Effects of administered medications were addressed. **Oxygen use:** Oxygen use not applicable. spm
 19:20 Electronic medical record closed. spm

Name: Aaliyah [REDACTED]

 MRN: K000629604
 Account#: K20033531813
 Page 2 of 3

Nurse's Notes Con't

Signatures:

Haynes, Andrew, MD	MD	ah	Mathews, Janet, RN	RN	jcm
Moore, Susan, RN	RN	spm	Gardner, Glyn, RN	RN	dgg
Scriptuser, MEDHOST		ms2	David, Syndee, RN	RN	sd4
Walker, Ansell, RT	RT	aw7	Baldrige, Mercedes, RN	RN	fmb
Jorden, Samuel, Scribe	Scribe	stj	Arnold, Amanda, RN	RN	aca

Name: Aaliyah [REDACTED]

Print Time: 4/13/2017 21:21:45

MRN: K000629604
Account#: K20033531813
Page 3 of 3

RUN DATE: 04/13/17 WILLIS-KNIGHTON HEALTH SYSTEM LABORATORIES PAGE 1
 RUN TIME: 0207 WKHS Summary Discharge Report
 WK=2600 Greenwood Rd WKS=2510 BertKounsIndLoop WKB=2400 Hospital Dr WKP=8001 Youree Dr
 Shreveport, LA 71103 Shreveport, LA 71118 Bossier City, LA 71112 Shreveport, LA 71115

PATIENT: [REDACTED] L ACCT #: K20033531813 LOC: ERS U #: K000629604
 DOB: 10/01/13 AGE/SX: 3Y 06M/F ROOM: REG: 04/12/17
 ATT DR: Haynes, Andrew T M.D. STATUS: DEP ER BED: DIS:

PCR TESTS

Date Time	APR 12 1733	Reference	Units
--------------	----------------	-----------	-------

Flu A	Negative	(Negative)	
Flu B	Negative	(Negative)	
Flu Comments	Comments (A).		

(A) NEGATIVE influenza test results do not preclude influenza virus infection and should not be used as the sole basis for treatment or other patient management decisions. False negative results may occur if virus is present at levels below the analytical limit of detection or the virus mutates in the target region.

Comments See Below (B)

(B) The results of this assay should be interpreted in conjunction with other laboratory and clinical data.

Willis-Knighton South
2510 Bert Kouns Industrial Loop
Shreveport, LA 71118

Patient Name: [REDACTED]
Adm No: K20033531813
DOB: 10/01/2013
Age: 3Y F
Corp ID: 000001116206

MRN: 1116206
Location: ER Patient - ERS
Ord No: 90014
Hospital: WKS

Ordering Dr: ANDREW THOMAS HAYNES

CC:

Final Report

Admitting Diagnosis: BREATHING DIFFICULTY FEVER
Reason For Exam: Fever
Procedure Date: 04/12/2017
Procedure: SXR - XR, chest 1 view portable

Interpretive Location: ABURGIN
Accession Number: 3592230
CPT Code: 71010

IMPRESSION: Normal portable chest.

RESULT:

Procedure: XR, chest 1 view portable

Clinical Information: Fever

Comparison: Chest radiograph from 1/29/2017

Findings:

Heart size and contour are normal for portable technique. The lungs are clear of infiltrate, mass, or effusion. No significant skeletal abnormality is noted.

Electronically Signed by: [REDACTED] JOSEPH BURGIN M.D. on Apr 12 2017 5:46P

Techs:

Additional Staff:

Read by: [REDACTED] JOSEPH BURGIN M.D. on Apr 12 2017 5:46P

Electronically Signed by: [REDACTED] JOSEPH BURGIN M.D. on Apr 12 2017 5:46P

Printed: Apr 12 2017 5:50PM

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Willis Knighton South and Center for Women's Health

Willis Knighton South2510 Bert Kouns Industrial Loop
Shreveport, LA 71118
318-212-5500HENDERSON, AALLYAH L
10/01/13 3Y 06M
Haynes, Andrew T M,
K20033531813 04/12/17

Discharge Instructions for: [REDACTED] L

Arrival Date:

04/12/17 17:08

Care Complete Time:

04/12/17 19:09

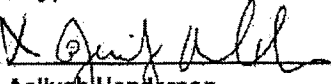
Thank you for choosing **Willis Knighton South** for your care today. The examination and treatment you have received in the Emergency Department today have been rendered on an emergency basis only and are not intended to be a substitute for an effort to provide complete medical care. You should contact your follow-up physician as it is important that you let him or her check you and report any new or remaining problems since it is impossible to recognize and treat all elements of an injury or illness in a single emergency care center visit.

Care provided by: Haynes, Andrew, MD

Diagnosis: Upper Respiratory Infection (URI); Asthma with Acute Exacerbation

DISCHARGE INSTRUCTIONS	FORMS
Asthma, Childhood Fever, Child (with Dosage Charts) Upper Respiratory Infection (URI), Child	None
FOLLOW UP INSTRUCTIONS	PRESCRIPTIONS
LSU/UH, KidMed clinic (LSU / University Clinic) When: 2 days	Orapred Amoxicillin
SPECIAL NOTES	
None	

I hereby acknowledge that I have received and understand the above instructions and prescriptions (if any).


Aallyah Henderson
MRN # K000629604


ED Physician or Nurse

X-RAYS and LAB TESTS:

If you had x-rays today they were read by the emergency physician. Your x-rays will also be read by a radiologist within 24 hours. If you had a culture done it will take 24 to 72 hours to get the results. If there is a change in the x-ray diagnosis or a positive culture, we will contact you. Please verify your current phone number prior to discharge at the check out desk.

MEDICATIONS:

If you received a prescription for medication(s) today, it is important that when you fill this you let the pharmacist know all the other medications that you are on and any allergies you might have. It is also important that you notify your follow-up physician of all your medications including the prescriptions you may receive today.

Chart Copy

FOLLOW UP INSTRUCTIONS

LSU/UH, KidMed clinic (LSU / University Clinic)
318-626-0015
When: 2 days



10/01/13 3Y 06M
Haynes, Andrew T M.
K20033531813 04/12/17

PRESCRIPTIONS

Orapred 15 mg/5 mL Oral Solution
Take 8 milliliter by ORAL route once daily for 5 days; 40 milliliter

Amoxicillin 400 mg/5 mL Oral Suspension for Reconstitution
Take 7 milliliter by ORAL route every 12 hours for 10 days; 140 milliliter

TESTS AND PROCEDURES

Labs

Influenza by PCR

Rad

Chest Xray Portable 1 View

Procedures

None

Other

Call X-Ray Tech, COLLECT SWAB

RUN DATE: 04/12/17
RUN TIME: 1721
RUN USER: SAFFED1.AM

Willis Knighton South *ADMISSIONS
INTERDISCIPLINARY ALLERGY SOURCE DOCUMENT

PAGE 1

Name: HENDERSON [REDACTED] L DOB: 10/01/13 Age: 3Y 06M
Rm/Bd: Serv/Locn: ERS Status: ER Sex: F
Unit#: K000629604 Account#: K20033531813 EPI#: 000000001116206

Last Update/
Acknowledgement:

Interdisciplinary Assessment (Free Text), historical data:

Allergy1-Med/Contact: NKDA	11/04/16 - 2201
Allergy2-Med/Contact: NKDA	11/04/16 - 2201
Food Allergies-Intol: NKFA	11/04/16 - 2201
Latex Allergy (Y/N): N	11/04/16 - 2201

Pharmacy Allergy List (Coded Allergies), historical data:

11/06/16

(Duplicate names represent coding within (3) categories:
Ingredient, Generic and Class allergy codes.)

NO KNOWN DRUG ALLERGIES, NO KNOWN FOOD ALLERGIES, NO KNOWN LATEX ALLERGY



HENDERSON [REDACTED] L
10/01/13 3Y 06M
Haynes, Andrew T M.
K20033531813 04/12/17

Interdisciplinary Allergy Source Document is a Permanent Part of
the Patient's Medical Record



ASSIGNMENT OF BENEFITS

1. Hospital Care Consent: I/we consent to hospital services, treatment and diagnostic procedures by the hospital as may be deemed necessary or advisable by my physician and/or consultants selected by my physician. The consent to hospital care includes permission for x-ray examinations, laboratory procedures, I.V. treatments, hepatitis test administration of blood and blood products, injections, medications, recording, filming or video monitoring for internal purposes only, and hospital services rendered the patient under the general and special instruction of doctors. The patient acknowledges responsibility for any or all of these procedures. It is the hospital policy that the patient has the opportunity to discuss surgery and procedures with the patient's doctor before hand. The patient has the right to consent to surgery and procedures. Except in emergencies or unusual circumstances, the hospital does not allow its facilities to be used without this discussion and patient's consent. I voluntarily give my consent to hospital care and accept the condition of hospitalization listed.

2. Authorizations for Release of Information: The employees and agents of this hospital and copy services and electronic claims processing services under contract with this hospital and any third party billing agents for this hospital or any of its staff physicians involved with patient care are given permission to release any and all information relating to the patient, including but not limited to the medical record of the patient's hospitalization, to another healthcare provider if the patient was transferred to that facility from this hospital and to any and all insurance companies or other third-party paying or obligated to pay, in whole or in part, the charges incurred by the patient in this hospital; and they are also given permission to release the above described information to any agent or firm working for or with the above described insurance companies or other third-party payors for the purpose of performing pre-certification, concurrent and/or retrospective review and/or other utilization review of any kind.

3. Valuables: I understand and acknowledge that the hospital assumes no responsibility for personal possessions including cash, jewelry, bridgework, eyeglasses or any other personal possession which I choose to keep in my room. I have been advised that such valuables should be placed in the care of my family or deposited in the hospital vault located in the Business Office.

4. Safety Code for Hospital: Safety Codes for hospitals issued by the National Fire Protection Association prevent the use in the hospital of any electrical equipment or accessories until they have been safety checked by the hospital's electrical engineer. Exceptions to this rule are hair and blow dryers, curling irons, hot rollers, radios, clocks, electric razors, shavers, contact lens sterilizers, electric toothbrushes and calculators.

5. Payment Guaranty and Assignment of Insurance Benefits: I, the undersigned patient, guardian, and/or guarantor (hereinafter "Debtor") hereby promise to pay in full Willis-Knighton Health System (WKHS) customary charges for the goods and services rendered to the patient identified on the reverse side hereof during this period of hospitalization (hereinafter "Indebtedness"). Debtor acknowledges and agrees that, unless waived in full by WKHS as set forth below, the Indebtedness accruing during this hospitalization is due and payable in such amounts and at such times during this hospitalization as WKHS may, in its sole discretion, determine, that the entire Indebtedness is due and payable in full at discharge. I acknowledge that, upon proof of acceptable insurance coverage, WKHS, in its sole discretion, may reduce the amount of indebtedness due and payable during this hospitalizations and the balance due at discharge. In such event, I understand that all deductibles, co-insurance, non-covered charges and other items not paid by insurance or other third-party payors shall be due and payable during this period of hospitalization and upon discharge as set forth hereinabove. I acknowledge and agree that in the event that WKHS, in its sole discretion, accepts proof of insurance coverage, claims for payment for benefits will be filed on behalf of the Debtor and/or the insured and that these benefits will be considered by WKHS in determining the amounts due as set forth hereinabove. I understand and agree that WKHS will accept payments from third-party payors and insurers on behalf of the Debtor and apply such payment to the indebtedness to the extent that they are received. I acknowledge and agree that the filing of such insurance and other third-party claims is performed as a service by WKHS and in no way relieves me of the obligation to pay the Indebtedness as agreed herein above.

Patient hereby appoints WKMC as Patient's authorized representative to file any necessary claim appeal(s) on Patient's behalf. In consideration for this appointment, WKMC agrees only to collect only applicable copayments, deductibles, and coinsurance for covered benefits from the Patient and waives any right to collect any other payments related to those covered benefits from the Patient.

Debtor hereby absolutely assigns to WKHS all insurance benefits on all policies of insurance under which Debtor is an insured, whether hospital, medical, liability or other insurance, and also hereby absolutely assigns to WKHS the proceeds of any judgment or settlement of any claim against any third party and any and all other amounts which may be determined in any manner to be payable to Debtor in connection with any injury suffered by the patient which gives rise to the Indebtedness incurred during this period of treatment. I hereby authorize WKHS to obtain any and all information related to such injuries, including, but not limited to, accident reports and agree to cooperate with WKHS in connection with the procurement of any information or documents WKHS deems in its sole discretion, necessary or appropriate in connection with the assignment made pursuant to this paragraph. I hereby authorize and direct that all such payments and proceeds shall be made directly to WKHS under the terms of this assignment. Any receipts from WKHS shall be applied towards Indebtedness but such application shall not relieve the Debtor from the Debtor's obligation to pay any remaining portion to the Indebtedness. Debtor acknowledges and agrees that, to the extent that the Indebtedness has not been satisfied by such receipts, that portion of the Indebtedness for which payment has been deferred pursuant to the preceding paragraph shall be due and payable in full on the thirtieth day following the date of service. In the event that WKHS receives proceeds and/or payments in excess of the Indebtedness, WKHS may apply such excess payment to any outstanding Indebtedness of Debtor to WKHS arising out of any other period(s) of treatment as well as any attorneys' fees and expenses for which Debtor may be liable hereunder. In the event that all Indebtedness has been paid

Admission Date: 04/12/17

Admission Time: 1708



AM0005



10/01/13 3Y F
Haynes, Andrew T M.D.
K20033631813 04/12/17



ASSIGNMENT OF BENEFITS

in full, then WKHS will refund the Debtor any such excess payment. Notwithstanding anything herein to the contrary, the assignments made hereby shall remain in full force and effect until the entire Indebtedness and any and all attorneys' fees and expenses for which Debtor may be liable have been paid in full. In the event that the Indebtedness is not paid when and as due as determined by WKHS hereunder, and the Indebtedness is placed in the hands of an attorney for purposes of collection, Debtor agrees to pay reasonable attorneys' fees, which are hereby acknowledged to be one-third (1/3) of the amount of the Indebtedness at the time the matter is placed in the hands of an attorney, plus any and all court costs and other expenses incurred in connection with the collection of the Indebtedness.

Financial assistance is available to all patients who meet the requirements of our charity care policy. Patients are encouraged to contact the Business Office if they have any concerns or need assistance in paying their bills. Our charity care policy is limited to hospital charges and does not include physician, anesthesiologist or professional charges that are not billed by the hospital. In addition, financial assistance is not offered for cosmetic, elective, experimental or other treatments and all hospital services must be ordered by your physician.

6. Assignment to Physicians: I understand that my physician as well as other physicians who treat me or otherwise involved in my care while a patient at the hospital are not employees or agents of the hospital and the hospital is not responsible for their actions. I further understand that my physician or other physicians will send me a separate bill for their services, in addition to the hospital bill. I hereby assign to all physicians who treat me the benefits due to me for these services covering medical and/or surgical expenses. I agree that should be the amount be insufficient to cover the entire medical/surgical expense, I will be responsible to said physicians for payment of the entire bill.

7. Medicare Consent: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act (SSA) is correct. I authorize Willis-Knighton Health System (WKHS) to provide (SSA) or its intermediaries with access to my medical/hospital record for the purpose of processing the Medicare claim for this or a related Medicare claim. I further request that WKHS provide such copies thereof as may be requested. Copies may be made by WKHS or its agents or contractors providing copy service and electronic claims processing services and said third party billing agents for hospital and staff physicians involved with patient care.

8. Champus/Medicare Notice: Champus/Medicare will not pay for private rooms unless medical justified, personal convenience items, diagnostic admissions or test or hospital stays not medically necessary. My signature below acknowledges my receipt of this information regarding Champus/Medicare from the hospital on the date indicated.

9. Willis-Knighton Health System (and our Medical Staff) will use and disclose your personal health information to treat you, to receive payment for the care we provide and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website and have copies available for distribution. I acknowledge that I have received a copy of the Notice of Privacy Practices.

This form has been fully explained to me. My signature reflects my understanding of the information contained herein. I further understand and acknowledge that all references to myself as the patient shall be deemed to apply as if rewritten in their entirety to a dependent for whom I am responsible for and/or who is unable to consent on their behalf for reasons indicated below.

I acknowledge that I have been informed of my rights and obligations as a patient.

	4-12-17				4/12/17
Signature of Patient/Guardian	Date/Time	Guarantor	Date/Time	Witness	Date/Time
Jennifer Alexander				Dorise Saffel	523A
Print Name		Print Name		Print Name	

If Patient/Guarantor is unable to sign, I, _____, do hereby state that I have been given the authority to sign for

_____, either expressed or implied and that he or she is fully aware of this authority.

Signature of Authorized Party	Authorized Party's Relationship to the Patient	Date/Time	Witness	Date/Time
----------------------------------	---	-----------	---------	-----------

Admission Date: 04/12/17
Admission Time: 1708



AM0005



10/01/13 SY F
Haynes, Andrew T M.D.
K20033531813 04/12/17

668

WILLIS-KNIGHTON MEDICAL CENTER
SHREVEPORT, LA
EMERGENCY ROOM REGISTRATION INFORMATION (3008)

NAME: [REDACTED] L

ACCT. NO: K33253907

GUARANTOR: ALEXANDER,JENNIFER

NEXT OF KIN: ALEXANDER,JENNIFER

ADDRESS: 3011 KITTY LN APT B
SHREVEPORT,LA 71107ADDRESS: 2247 LEGARDY STREET
SHREVEPORT,LA 71107

PHONE: (318)210-3821

PHONE: (318)210-3821

RELATION: M

GUAR EMPLOYER: CHILD

ADDRESS:

ARRIVED FROM: C

ATTENDING PHYS: Willis Jr, Fred Spence M.D.

PHONE:

ADMIT/OTHER PHYS:

PRIM CARE PHYS: UNKNOWN

	NAME	POLICY #	GROUP #	BENEFIT PLAN
PRIMARY INS:	LA HLTHCARE CONN LA ME	1997286459512	[REDACTED] L	MEDICAID
SECONDARY INS:				
TERTIARY INS:				
FOURTH INS:				

ACCT NO: K33253907

DATE: 01/29/17

UNIT#: K000629604

ROOM:

TIME: 0716

F/C: MA

STATUS: REG ER

SERV/LOC: ERS

SS#: 338-89-3614

PATIENT: [REDACTED] L

BIRTHDATE: 10/01/13

ADDRESS: 2247 LEGARDY STREET
SHREVEPORT,LA 71107

AGE: 3Y

SEX: F

PHONE: (318)210-3821

RACE: BLACK OR AFRICAN AME

RELIGION: NO RELIGION

COUNTY: CADD0 PARISH

MARITAL STAT: SINGLE

EMPLOYER: GOD'S GIFT

PERSON TO NOTIFY: ALEXANDER,JENNIFER

ADDRESS: 2305 MARIAN PL
SHREVEPORT,LA 71109ADDRESS: 2247 LEGARDY STREET
SHREVEPORT,LA 71107

000-0000

PHONE: (318)210-3821

RELATION: M

Is the Patient here for Pre-Op Testing:

Comments:

Admit Clerk: MORANCAM

Reason for Visit: FEVER RUNNY NOSE

Baby ID#:

Known Drug Allergies: U

HIPPA Notice Given: Y

Date Notice Given: 09/23/14

Device Id: AMSPC5

Interpreter ID Number:

Patient Survey: N

Preferred Language: ENGLISH

Ethnicity: NHILAT

Do you have an advaced directive that you would like to present to us today? N



K33253907

Physician Documentation

Willis Knighton South

Name: Aaliyah [REDACTED]
Age: 3 yrs Sex: Female DOB: 10/01/2013
Arrival Date: 01/29/2017 Time: 07:16
Bed 3

MRN: 1116206
Account#: K33253907
Private MD: LSU HOSPITAL, LSU

HPI:

01/29 This 3 years old African Am/Black Female presents to ED via Ambulatory with complaints of **Fever, Runny** kr2
10:42 **Nose, Cough.**
10:42 The patient presents to the emergency department with congestion, cough, fever, that is subjective, that was kr2
measured at 103 degrees Fahrenheit, wheezing. Onset: The symptoms/episode began/occurred yesterday.
Associated signs and symptoms: Pertinent positives: congestion, cough, fever, nasal discharge, wheezing,
Pertinent negatives: abdominal pain, constipation, diarrhea, earache, headache, seizure, shortness of
breath, sore throat, vomiting.
10:45 Modifying factors: The patient symptoms are alleviated by nothing, the patient symptoms are aggravated by kr2
nothing. Treatment prior to arrival: none. The patient has not experienced similar symptoms in the past. The
patient has not recently seen a physician.

Historical:

- **Allergies:** No known drug Allergies:
- **Home Meds:**
 1. Albuterol Nebulizer as needed
- **PMHx:** Autism; Reactive Airway Disease
- **PSHx:** None

Historical:

07:30 Family history: No immediate family members are acutely ill. Immunization history: Childhood immunizations sh1
up to date, Last flu immunization: up to date. Last tetanus immunization: up to date. Social history: The
patient lives with parents The patient speaks appropriately for age, The patient attends special school for
autistic children.
10:45 The history from nurses notes was reviewed and confirmed. kr2

ROS:

10:45 ROS as in the HPI, and all other systems were reviewed negative, or noncontributory, except as mentioned kr2
below. **Eyes:** Negative for injury, swelling, pain, visual disturbance or loss, FB sensation, redness, and
discharge. **Neck:** Negative for injury, pain, stiffness, and swelling **Cardiovascular:** Negative for chest pain,
palpitations, and edema, **Abdomen/GI:** Negative for abdominal pain, nausea, vomiting, diarrhea, and
constipation, hematochezia, hematemesis, melena, anorexia, dysphagia, injury, distention **Back:** Negative
for injury, pain, deformity, and decreased ROM **GU:** Negative for injury, pain, bleeding, discharge,
incontinence, and swelling, **MS/Extremity:** Negative for injury, pain, swelling, and decreased ROM **Skin:**
Negative for injury, swelling, discoloration, rash, and lesions **Neuro:** Negative for altered mental status,
headache, weakness, numbness, tingling, and seizure **Psych:** Negative for depression, anxiety, suicide
ideation, homicidal ideation, auditory hallucinations, visual hallucinations, and delusions. **Constitutional:**
Positive for coughing, Negative for chills, fever, obvious distress, poor PO intake, shortness of breath,
vomiting. **ENT:** Positive for nasal discharge, sinus congestion, Negative for difficulty swallowing,
hoarseness, nose bleed, pulling at ears, sinus pain, sore throat. **Respiratory:** Positive for cough, with no
reported sputum, wheezing, Negative for dyspnea on exertion, hemoptysis, orthopnea, pleurisy, paroxysmal
nocturnal dyspnea, shortness of breath.

Exam:

10:45 kr2
Constitutional: Well developed, well nourished child who is awake, alert and cooperative with no acute
distress.
Head/Face: Normocephalic, atraumatic.
Eyes: Pupils equal round and reactive to light, extra-ocular motions intact, no evidence of conjunctivitis. Lids
and lashes normal
Neck: Supple. Trachea midline. Normal thyroid with no lymphadenopathy or masses. Normal ROM without
pain. No vertebral point tenderness. No meningismus, no nuchal rigidity Lymphatic No abnormal

Physician Documentation Con't.

lymphadenopathy noted by palpation in the neck or axilla

Chest/axilla: Normal chest wall appearance and motion. Nontender, no deformity. No lesions appreciated. No axillary lymphadenopathy

Cardiovascular: Regular rate and rhythm with a normal S1 and S2. No gallops, murmurs, or rubs. Normal PMI, no JVD. No pulse deficits.

Respiratory: Lungs have equal breath sounds bilaterally, clear to auscultation and percussion. No rales, rhonchi or wheezes noted. No increased work of breathing, no retractions or nasal flaring.

Abdomen/GI: Soft, non-tender, nondistended no mass, no hepatosplenomegaly. No rebound or guarding. Bowel sounds present all quadrants. No hernia noted.

Back: Normal inspection with no obvious deformity. No spinal or CVA tenderness. Normal ROM without pain.

Skin: Warm and dry with excellent turgor. Normal color with no rashes, pallor, or cellulitis.

MS/ Extremity: Pulses equal. no clubbing, cyanosis, or edema. Neurovascular intact. Full, normal range of motion without pain.

Neuro: Awake and alert, oriented to person, place, time, and situation. Good muscle tone. Moves all extremities. GCS 15. Sensory grossly intact. Normal speech and gait for age.

Psych: Behavior and affect are normal for age. No delusions.

ENT: External ear(s): are unremarkable, no erythema, no cellulitis, no abscess, no swelling, no pain with movement, Ear canal(s): abscess, is not appreciated, bleeding, is not appreciated, bloody discharge, is not appreciated, cerumen impaction, is not appreciated, erythema, that is moderate, bilaterally, foreign body, is not appreciated, purulent discharge, is not appreciated, swelling, is not appreciated, TM's: bulging, on the right, decreased mobility, is not appreciated, dullness, on the right, erythema, that is moderate, bilaterally, fluid levels, is not appreciated, hemotympanum, is not appreciated, loss of bony landmarks, is not appreciated, rupture, is not appreciated, Nose: is normal, no abscess, no bleeding, no drainage, no edema, no erythema, no laceration, no swelling, Mouth: is normal, no gum abnormalities, no lip abnormalities, no mucosal abnormalities, no tongue abnormalities. Posterior pharynx: Airway: normal, no evidence of obstruction, Tonsils: with erythema, no enlargement, no exudate, no ulcerations, Uvula: normal, midline, swelling, is not appreciated, erythema, that is moderate, exudate, is not appreciated, peritonsillar mass, is not appreciated, pooling of secretions, is not appreciated.

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Height	Pain	Staff
07:24			24	98.6(TE)	96% on R/A	15.42 kg / 34 lbs 0 oz	38 in. (97 cm)	0/10	sh1

07:24 pt is autistic and difficult to get vital signs fighting the nurse at triage unable to get axillary temp

sh1

Glasgow Coma Score:

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
07:24	spontaneous(4)	oriented(5)	obeys commands(6)		15	sh1

MDM:

08:16 Patient medically screened.

sw2

10:45

kr2

Data reviewed: vital signs, nurses notes, and as a result, I will continue to observe the patient, order radiologic study(s), plain X-ray(s).

Counseling: I had a detailed discussion with the patient and/or guardian regarding: the historical points, exam findings, and any diagnostic results supporting the discharge/admit diagnosis, radiology results, the need for outpatient follow up, to return to the emergency department if symptoms worsen or persist or if there are any questions or concerns that arise at home.

11:14

Differential Diagnosis viral infection, bacterial infection, URI, bronchitis, pneumonia, UTI, gastroenteritis, meningitis. I personally performed the services described in this documentation as scribed in my presence, and it is both accurate and complete.

sw2

Name: Aaliyah [REDACTED]

MRN: 1116206
Account#: K33253907

Print Time: 10/1/2019 10:01:26

Page 2 of 4

Physician Documentation Con't.**Data interpreted:** Pulse oximetry: normal.**Response to treatment:** the patient's symptoms have markedly improved after treatment.

Order	Status	Time	By	For				
Call X-Ray Tech	Ordered	01/29/17 08:16	sw2	sw2				
	Completed	01/29/17 08:21	Kristen Gray					
Notes:	Order Method: Electronic							
Order	Status	Time	By	For				
Chest 2 View *routine*	Ordered	01/29/17 08:16	sw2	sw2				
	Reviewed	01/29/17 10:49	Fred Willis					
Notes: Bed Name: 3	Order Method: Electronic							
Interpretation: NEGATIVE ACUTE.								
ER EXAM ROOM/BED: (OERDERRMBD): 3								
MODE OF TRANSPORTATION : (OERDTRANS): STRETCHER								
O2: (OEADO2): No								
REASON FOR EXAM: (OERDEXAM): Fever								
Order	Status	Time	By	For				
COLLECT SWAB	Ordered	01/29/17 08:16	sw2	sw2				
	Completed	01/29/17 08:32	Cindy Colon					
Notes:	Order Method: Electronic							
Order	Status	Time	By	For				
Influenza and RSV Panel by PCR	Ordered	01/29/17 08:16	sw2	sw2				
	Reviewed	01/29/17 10:49	Fred Willis					
Notes:	Order Method: Electronic							
Interpretation: Normal.								
Ordering Location: ERSPC100.1								
Order	Status	Time	By	For				
Rocephin 500 mg with Lidocaine 1% as diluent - (Rocephin 500 mg, Lidocaine 1 mL) IM once	Ordered	01/29/17 10:49	sw2	sw2				
	Administered	01/29/17 11:22	cc1					
Notes:	Order Method: Electronic							
01/29/17 11:22	Administered: Rocephin 500 mg with Lidocaine 1% as diluent - (Rocephin 500 mg, Lidocaine 1 mL) IM in right gluteus			cc1				
01/29/17 11:42	Follow Up: Response: No Adverse Reaction; Reassessment at discharge; Tolerated well			cc1				

Order Signatures:

Willis, Fred, MD

MD sw2

Disposition:

10:45 This chart was scribed by Rowe. Kristina. Scribe. in the presence of Fred Willis MD.

kr2

Name: Aaliyah

MRN: 1116206
Account#: K33253907

Print Time 10/1 2019 10 01 26

Page 3 of 4

Physician Documentation Con't.

11:14 Electronically signed by: FRED WILLIS JR MD. Disposition.

sw2

11:16 Disposition.

sw2

Disposition:

01/29/17 11:15 Discharged to Home/Self Care. Impression: Bronchitis Acute, Fever, Otitis Media, Pharyngitis.

- Condition is Stable.
- Discharge Instructions: Bronchitis.
- Prescriptions for
 - Amoxicillin 400 mg/5 mL Oral Suspension for Reconstitution
 - take 9 milliliter by ORAL route every 12 hours for 10 days: 180 milliliter.
 - Robitussin
 - CF Oral Suspension - take 3 milliliter by ORAL route every 6-8 hours As needed; 60 milliliter.
- Follow up: LSU LSU HOSPITAL; When: Tomorrow.
- Problem is new.
- Symptoms have improved.

Signatures:

Hovingh, Sue, RN

RN sh1

Willis, Fred, MD

MD sw2

Gray, Kristen, ED Tech

ED
Tech kg1

Colon, Cindy, RN

RN cc1

Rowe, Kristina, Scribe

Scribe kr2

Name: Aaliyah [REDACTED]

MRN: 1116206
Account#: K33253907
Page 4 of 4

Nurse's Notes

Name: Aaliyah
Age: 3 yrs Sex: Female DOB: 10/01/2013
Arrival Date: 01/29/2017 Time: 07:16
Bed 3

Willis Knighton South

MRN: 1116206
Account#: K33253907
Private MD: LSU HOSPITAL, LSU

Presentation:

01/29 Method of Arrival: Ambulatory. sh1
07:22 Preferred language for medical communication is English. Presenting complaint: Mother states: started running a fever of 103 yesterday with a runny nose cough and some wheezing has been doing breathing treatments says her wheezing is better but still running fever. Person Transporting: Parent. Transition of care: patient was not received from another setting of care. Care prior to arrival: Medications: Tylenol, at 0530. sh1
07:29 Acuity: 3 - Urgent. sh1

Triage Assessment:

07:24 **General:** Appears in no apparent distress, well developed, well nourished, well groomed, Behavior is appropriate for age, pt is autistic. **Pain:** FACES pain scale score is 0 out of 10. sh1

Historical:

- **Allergies:** No known drug Allergies;
- **Home Meds:**
 1. Albuterol Nebulizer as needed
- **PMHx:** Autism; Reactive Airway Disease
- **PSHx:** None

Historical:

07:30 Family history: No immediate family members are acutely ill. Immunization history: Childhood immunizations up to date, Last flu immunization: up to date. Last tetanus immunization: up to date. Social history: The patient lives with parents The patient speaks appropriately for age. The patient attends special school for autistic children. sh1
10:45 The history from nurses notes was reviewed and confirmed. kr2

Screening:

07:24 **Abuse screen:** sh1
Denies threats or abuse.
Patient fall risk assessment;
risks identified; None.
Learning Barriers:
age barrier identified, caregiver ready and willing to learn.
Pedi Fall Risk
None Identified.
Exposure risk/Travel Screening:
None identified.

Assessment:

08:15 **Pain:** Complains of pain in left ear Pain does not radiate. level that is acceptable is 0 out of 10 on a pain scale. FACES pain scale score is 2 out of 10. Quality of pain is described as. cc1
08:15 **General:** Appears in no apparent distress, well developed, Behavior is appropriate for age, mobility; ambulates without assistance Reports fever for 1-2 days, per mother. **Neuro:** Level of Consciousness is alert, awake, obeys commands, appropriate to pain. Oriented to person, place, time, Grips are equal bilaterally Moves all extremities. Full function in bilateral Gait is steady, Speech is normal, Facial symmetry appears normal. Pupils are PERRLA. **EENT:** Ear canal clear on left ear Oral mucosa is moist. Throat is clear bilaterally with gag reflex present, Parent/caregiver reports the patient having pain in left ear nasal congestion nasal discharge. **Cardiovascular:** Capillary refill < 3 seconds is brisk in bilateral Heart tones S1 S2 present. **Respiratory:** Respiratory effort is even, unlabored, relaxed, Respiratory pattern is regular, symmetrical, Airway is patent Trachea midline Breath sounds are clear bilaterally. Parent/caregiver reports the patient having cough that is persistent for 2 day(s). **Gastrointestinal:** Parent/caregiver reports the patient having normal bowel habits. **Genitourinary:** Parent/caregiver reports the patient having normal urinary habits. **Dermatologic:** Skin is intact, is healthy with good turgor, Skin is dry, Skin is normal, Skin temperature is warm. **Musculoskeletal:** No deficits noted. Age appropriate behavior- Toddler (12 months to 4 yrs):. cc1

Vital Signs:

Nurse's Notes Con't

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Height	Pain	Staff
07:24		107	24	98.6(TE)	96% on R/A	15.42 kg / 34 lbs 0 oz	38 in. (97 cm)	0/10	sh1

07:24 pt is autistic and difficult to get vital signs fighting the nurse at triage unable to get axillary temp sh1

Vitals:

07:24 Acuity: 3 - Urgent. sh1

11:42 Body Mass Index = 16.39. cc1

Glasgow Coma Score:

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
07:24	spontaneous(4)	oriented(5)	obeys commands(6)		15	sh1

ED Course:

07:16 Patient arrived in ED. ms2
 07:16 Patient moved to KIOSK. ms2
 07:24 LSU HOSPITAL, LSU is Private Physician. sh1
 07:30 Triage completed. sh1
 07:32 Patient moved to Waiting. sh1
 08:15 Patient moved to 3. cc1
 08:15 Side rails up X 1. Bed in low position. Patient has correct armband on for positive identification. Adult with patient. Child being held by parent. Family accompanied patient Family updated on plan of care Family mother with patient. cc1
 08:16 Willis, Fred. MD is Attending Physician. sw2
 08:17 Colon, Cindy, RN is Primary Nurse. cc1
 08:33 Patient moved to Radiology. md
 08:33 Chest 2 View *routine* Sent. md
 08:39 Patient moved to 3. jsr
 11:15 LSU HOSPITAL, LSU is Referral Physician. sw2
 11:18 Special Handling: Hold Discharge. cc1
 11:18 No apparent distress. Awaiting post injection time. cc1
 11:42 Special Handling: Hold Discharge. cc1
 11:42 No procedures done that require assistance. cc1

Administered Medications:

Time	Drug & Dose <i>Dispensable & Quantity</i>	Volume	Route	Rate	Infused Over	Site	Delivery	Staff
11:22	Rocephin 500 mg with Lidocaine 1% as diluent - (Rocephin 500 mg, Lidocaine 1 mL)		IM			right gluteus		cc1
11:42	Follow up: Response: No Adverse Reaction; Reassessment at discharge; Tolerated well							cc1

Outcome:

11:15 Discharge ordered by MD. sw2
 11:42 Discharged to home, carried, with family. Discharge instructions given to Mother Instructed on discharge instructions, follow up and referral plans, medication usage, fever management, handwashing Demonstrated cc1

Name: Aaliyah [REDACTED]

MRN: 1116206
 Account#: K33253907
 Page 2 of 3

Nurse's Notes Con't

understanding of instructions, medications, Prescriptions given; 2, No questions or concerns expressed to me at discharge. No belongings were removed by WK staff. **Medication reconciliation form provided.**

Med Effects: Effects of administered medications were addressed. **Oxygen use:** Oxygen use not applicable.

11:43 Electronic medical record closed.

cc1

Signatures:

Hovingh, Sue, RN	RN sh1	Durr, Melinda, RT	RT md
Rivers, Jaime, RT	RT jsr	Willis, Fred, MD	MD sw2
Scriptuser, MEDHOST	ms2	Colon, Cindy, RN	RN cc1
Rowe, Kristina, Scribe	Scribe kr2		

RUN DATE: 10/01/19
RUN TIME: 1347
RUN USER: PARRM.HM

Laboratory System *Live*
WKS Discharge Summary Report

PAGE 1

LOCATION

PATIENT: [REDACTED] L ACCT #: K33253907 LOC: ERS U #: K000629604
AGE/SX: 3Y 03M/F ROOM: REG: 01/29/17
REG DR: Willis Jr, Fred Spence STATUS: DEP ER BED: DIS:

PCR TESTS

Day	1		
Date	JAN 29		
Time	0824	Reference	Units
=> Flu A	(a)	(Negative)	
=> Flu B	(b)	(Negative)	
=> Flu Comments	(c)		
=> RSV	(e)	(Negative)	
=> Comments	(g)		

NOTES: (a) Negative
(b) Negative
(c) Comments
See also (d)
(d) NEGATIVE influenza test results do not preclude influenza virus infection and should not be used as the sole basis for treatment or other patient management decisions. False negative results may occur if virus is present at levels below the analytical limit of detection or the virus mutates in the target region.
(e) Negative
See also (f)
(f) NEGATIVE test results do not preclude RSV infection and should not be used as the sole basis for treatment or other patient management decisions. False negative results may occur if virus is present at levels below the analytical limit of detection or the virus mutates in the target region.
(g) See Below
See also (h)
(h) The results of this assay should be interpreted in conjunction with other laboratory and clinical data.

Patient: [REDACTED] L Age/Sex: 3Y 03M/F Acct#K33253907 Unit#K000629604

WILLIS-KNIGHTON SOUTH EPI: 000000001116206
Account: K33253907 XR REPORT
Patient: [REDACTED] L REG ER
Order Dr: Willis Jr, Fred Spence M.D. DOB: 10/01/13

Final Report

Admitting Diagnosis: FEVER RUNNY NOSE
Reason For Exam: Fever Interpretive Location: ZAMANI
Procedure Date: 01/29/2017 Accession Number: 3497430
Procedure: SXR - XR, chest 2 view CPT Code: 71020

IMPRESSION: Questionable left perihilar infiltrate suggestive of pneumonia. Clinical correlation and follow-up chest radiograph are recommended.

RESULT: PA AND LATERAL CHEST

Clinical Information: Fever

Comparison: November 6, 2016

Findings: Small left perihilar infiltrate is suspected. The study is limited by shallow inspiration and rotation. No effusion or pneumothorax is seen. Heart size is normal.

Electronically Signed by: RAMIN ZAMANI M.D. on Jan 29 2017 10:58A
3497430

Willis Knighton PCI **LIVE** (PCI: OE Database WKS)

RUN DATE: 01/29/17
RUN TIME: 0732
RUN USER: MORANC.AM

Willis Knighton South *ADMISSIONS
INTERDISCIPLINARY ALLERGY SOURCE DOCUMENT

PAGE 1

Name: [REDACTED] L DOB: 10/01/13 Age: 3Y 03M
Rm/Bd: Serv/Locn: ERS Status: ER Sex: F
Unit#: K000629604 Account#: K33253907 EPI#: 000000001116206

Last Update/
Acknowledgement:


Interdisciplinary Assessment (Free Text), historical data:

Allergy1-Med/Contact: NKDA	11/04/16 - 2201
Allergy2-Med/Contact: NKDA	11/04/16 - 2201
Food Allergies-Intol: NKFA	11/04/16 - 2201
Latex Allergy (Y/N): N	11/04/16 - 2201

Pharmacy Allergy List (Coded Allergies), historical data:
(Duplicate names represent coding within (3) categories:
Ingredient, Generic and Class allergy codes.)

11/06/16

NO KNOWN DRUG ALLERGIES, NO KNOWN FOOD ALLERGIES, NO KNOWN LATEX ALLERGY


HENDERSON, AALIYAH L
10/01/13 3Y 03M
Willis Jr, Fred Spe 01/29/17
K33253907

Interdisciplinary Allergy Source Document is a Permanent Part of
the Patient's Medical Record

Willis Knighton South and Center for Women's Health

Willis Knighton South2510 Bert Kouns Industrial Loop
Shreveport, LA 71118
318-212-5500

Discharge Instructions for: [REDACTED] L

Arrival Date:

01/29/17 07:16

Care Complete Time:

01/29/17 11:15

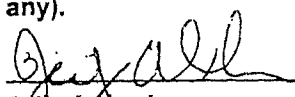
Thank you for choosing Willis Knighton South for your care today. The examination and treatment you have received in the Emergency Department today have been rendered on an emergency basis only and are not intended to be a substitute for an effort to provide complete medical care. You should contact your follow-up physician as it is important that you let him or her check you and report any new or remaining problems since it is impossible to recognize and treat all elements of an injury or illness in a single emergency care center visit.

Care provided by: Willis, Fred, MD

Diagnosis: Bronchitis Acute; Fever; Pharyngitis; Otitis Media

DISCHARGE INSTRUCTIONS	FORMS
Bronchitis	None
FOLLOW UP INSTRUCTIONS	PRESCRIPTIONS
LSU HOSPITAL, LSU (LSU Clinic) When: Tomorrow	Amoxicillin Robitussin-CF
SPECIAL NOTES	
None	

I hereby acknowledge that I have received and understand the above instructions and prescriptions (if any).


Aaliyah Henderson
MRN # K000629604


ED Physician or Nurse


X-RAYS and LAB TESTS:

If you had x-rays today they were read by the emergency physician. Your x-rays will also be read by a radiologist within 24 hours. If you had a culture done it will take 24 to 72 hours to get the results. If there is a change in the x-ray diagnosis or a positive culture, we will contact you. Please verify your current phone number prior to discharge at the check out desk.

MEDICATIONS:

If you received a prescription for medication(s) today, it is important that when you fill this you let the pharmacist know all the other medications that you are on and any allergies you might have. It is also important that you notify your follow-up physician of all your medications including the prescriptions you may receive today.

Chart Copy



10/01/13 3Y 03M L
Willis Jr, Fred Spe
K33253907 01/29/17

FOLLOW UP INSTRUCTIONS

LSU HOSPITAL, LSU (LSU Clinic)
318-675-5000
When: Tomorrow

PRESCRIPTIONS

Amoxicillin 400 mg/5 mL Oral Suspension for Reconstitution
Take 9 milliliter by ORAL route every 12 hours for 10 days; 180 milliliter

Robitussin-CF Oral Suspension
Take 3 milliliter by ORAL route every 6-8 hours As needed; 60 milliliter

TESTS AND PROCEDURES

Labs

Influenza and RSV Panel by PCR

Rad

Chest 2 View *routine*

Procedures

None

Other

Call X-Ray Tech, COLLECT SWAB



10/01/13 3Y 03M L
Willis Jr, Fred Spe
K33253907 01/29/17



ASSIGNMENT OF BENEFITS

1. Hospital Care Consent: I/we consent to hospital services, treatment and diagnostic procedures by the hospital as may be deemed necessary or advisable by my physician and/or consultants selected by my physician. The consent to hospital care includes permission for x-ray examinations, laboratory procedures, I.V. treatments, hepatitis test administration of blood and blood products, injections, medications, recording, filming or video monitoring for internal purposes only, and hospital services rendered the patient under the general and special instruction of doctors. The patient acknowledges responsibility for any or all of these procedures. It is the hospital policy that the patient has the opportunity to discuss surgery and procedures with the patient's doctor before hand. The patient has the right to consent to surgery and procedures. Except in emergencies or unusual circumstances, the hospital does not allow its facilities to be used without this discussion and patient's consent. I voluntarily give my consent to hospital care and accept the condition of hospitalization listed.

2. Authorizations for Release of Information: The employees and agents of this hospital and copy services and electronic claims processing services under contract with this hospital and any third party billing agents for this hospital or any of its staff physicians involved with patient care are given permission to release any and all information relating to the patient, including but not limited to the medical record of the patient's hospitalization, to another healthcare provider if the patient was transferred to that facility from this hospital and to any and all insurance companies or other third-party paying or obligated to pay, in whole or in part, the charges incurred by the patient in this hospital; and they are also given permission to release the above described information to any agent or firm working for or with the above described insurance companies or other third-party payors for the purpose of performing pre-certification, concurrent and/or retrospective review and/or other utilization review of any kind.

3. Valuables: I understand and acknowledge that the hospital assumes no responsibility for personal possessions including cash, jewelry, bridgework, eyeglasses or any other personal possession which I choose to keep in my room. I have been advised that such valuables should be placed in the care of my family or deposited in the hospital vault located in the Business Office.

4. Safety Code for Hospital: Safety Codes for hospitals issued by the National Fire Protection Association prevent the use in the hospital of any electrical equipment or accessories until they have been safety checked by the hospital's electrical engineer. Exceptions to this rule are hair and blow dryers, curling irons, hot rollers, radios, clocks, electric razors, shavers, contact lens sterilizers, electric toothbrushes and calculators.

5. Payment Guaranty and Assignment of Insurance Benefits: I, the undersigned patient, guardian, and/or guarantor (hereinafter "Debtor") hereby promise to pay in full Willis-Knighton Health System (WKHS) customary charges for the goods and services rendered to the patient identified on the reverse side hereof during this period of hospitalization (hereinafter "Indebtedness"). Debtor acknowledges and agrees that, unless waived in full by WKHS as set forth below, the Indebtedness accruing during this hospitalization is due and payable in such amounts and at such times during this hospitalization as WKHS may, in its sole discretion, determine, that the entire Indebtedness is due and payable in full at discharge. I acknowledge that, upon proof of acceptable insurance coverage, WKHS, in its sole discretion, may reduce the amount of indebtedness due and payable during this hospitalizations and the balance due at discharge. In such event, I understand that all deductibles, co-insurance, non-covered charges and other items not paid by insurance or other third-party payors shall be due and payable during this period of hospitalization and upon discharge as set forth hereinabove. I acknowledge and agree that in the event that WKHS, in its sole discretion, accepts proof of insurance coverage, claims for payment for benefits will be filed on behalf of the Debtor and/or the insured and that these benefits will be considered by WKHS in determining the amounts due as set forth hereinabove. I understand and agree that WKHS will accept payments from third-party payors and insurers on behalf of the Debtor and apply such payment to the indebtedness to the extent that they are received. I acknowledge and agree that the filing of such insurance and other third-party claims is performed as a service by WKHS and in no way relieves me of the obligation to pay the Indebtedness as agreed herein above.

Patient hereby appoints WKMC as Patient's authorized representative to file any necessary claim appeal(s) on Patient's behalf. In consideration for this appointment, WKMC agrees only to collect only applicable copayments, deductibles, and coinsurance for covered benefits from the Patient and waives any right to collect any other payments related to those covered benefits from the Patient.

Debtor hereby absolutely assigns to WKHS all insurance benefits on all policies of insurance under which Debtor is an insured, whether hospital, medical, liability or other insurance, and also hereby absolutely assigns to WKHS the proceeds of any judgment or settlement of any claim against any third party and any and all other amounts which may be determined in any manner to be payable to Debtor in connection with any injury suffered by the patient which gives rise to the Indebtedness incurred during this period of treatment. I hereby authorize WKHS to obtain any and all information related to such injuries, including, but not limited to, accident reports and agree to cooperate with WKHS in connection with the procurement of any information or documents WKHS deems in its sole discretion, necessary or appropriate in connection with the assignment made pursuant to this paragraph. I hereby authorize and direct that all such payments and proceeds shall be made directly to WKHS under the terms of this assignment. Any receipts from WKHS shall be applied towards Indebtedness but such application shall not relieve the Debtor from the Debtor's obligation to pay any remaining portion to the Indebtedness. Debtor acknowledges and agrees that, to the extent that the Indebtedness has not been satisfied by such receipts, that portion of the Indebtedness for which payment has been deferred pursuant to the preceding paragraph shall be due and payable in full on the thirtieth day following the date of service. In the event that WKHS receives proceeds and/or payments in excess of the Indebtedness, WKHS may apply such excess payment to any outstanding Indebtedness of Debtor to WKHS arising out of any other period(s) of treatment as well as any attorneys' fees and expenses for which Debtor may be liable hereunder. In the event that all Indebtedness has been paid

Admission Date: 01/29/17

Admission Time: 0716



AM0005



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10/01/13 3Y F
Willis Jr, Fred Spence M.D.
K33253907 01/29/17



WILLIS-KNIGHTON HEALTH SYSTEM

ASSIGNMENT OF BENEFITS

in full, then WKHS will refund the Debtor any such excess payment. Notwithstanding anything herein to the contrary, the assignments made hereby shall remain in full force and effect until the entire Indebtedness and any and all attorneys' fees and expenses for which Debtor may be liable have been paid in full. In the event that the Indebtedness is not paid when and as due as determined by WKHS hereunder, and the Indebtedness is placed in the hands of an attorney for purposes of collection, Debtor agrees to pay reasonable attorneys' fees, which are hereby acknowledged to be one-third (1/3) of the amount of the Indebtedness at the time the matter is placed in the hands of an attorney, plus any and all court costs and other expenses incurred in connection with the collection of the Indebtedness.

Financial assistance is available to all patients who meet the requirements of our charity care policy. Patients are encouraged to contact the Business Office if they have any concerns or need assistance in paying their bills. Our charity care policy is limited to hospital charges and does not include physician, anesthesiologist or professional charges that are not billed by the hospital. In addition, financial assistance is not offered for cosmetic, elective, experimental or other treatments and all hospital services must be ordered by your physician.

6. Assignment to Physicians: I understand that my physician as well as other physicians who treat me or otherwise involved in my care while a patient at the hospital are not employees or agents of the hospital and the hospital is not responsible for their actions. I further understand that my physician or other physicians will send me a separate bill for their services, in addition to the hospital bill. I hereby assign to all physicians who treat me the benefits due to me for these services covering medical and/or surgical expenses. I agree that should be the amount be insufficient to cover the entire medical/surgical expense, I will be responsible to said physicians for payment of the entire bill.

7. Medicare Consent: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act (SSA) is correct. I authorize Willis-Knighton Health System (WKHS) to provide (SSA) or its intermediaries with access to my medical/hospital record for the purpose of processing the Medicare claim for this or a related Medicare claim. I further request that WKHS provide such copies thereof as may be requested. Copies may be made by WKHS or its agents or contractors providing copy service and electronic claims processing services and said third party billing agents for hospital and staff physicians involved with patient care.

8. Champus/Medicare Notice: Champus/Medicare will not pay for private rooms unless medical justified, personal convenience items, diagnostic admissions or test or hospital stays not medically necessary. My signature below acknowledges my receipt of this information regarding Champus/Medicare from the hospital on the date indicated.

9. Willis-Knighton Health System (and our Medical Staff) will use and disclose your personal health information to treat you, to receive payment for the care we provide and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website and have copies available for distribution. I acknowledge that I have received a copy of the Notice of Privacy Practices.

This form has been fully explained to me. My signature reflects my understanding of the information contained herein. I further understand and acknowledge that all references to myself as the patient shall be deemed to apply as if rewritten in their entirety to a dependent for whom I am responsible for and/or who is unable to consent on their behalf for reasons indicated below.

I acknowledge that I have been informed of my rights and obligations as a patient.

	1-29-17		1-29-17		1-29-17
Signature of Patient/Guardian	Date/Time	Guarantor	Date/Time	Witness	Date/Time
Jennifer Alexander	7:16		7:15	Cynthia Mora	7:16
Print Name		Print Name		Print Name	

If Patient/Guarantor is unable to sign, I, _____, do hereby state that I have been given the authority to sign for

_____, either expressed or implied and that he or she is fully aware of this authority.

_____ Signature of Authorized Party	_____ Authorized Party's Relationship to the Patient	_____ Date/Time	_____ Witness	_____ Date/Time
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Admission Date: 01/29/17
Admission Time: 0716



AM0005



10/01/13 3Y F
Willis Jr, Fred Spence M.D.
K33253907 01/29/17

Printed: 11/04/2016

WILLIS-KNIGHTON HEALTH SYSTEM

FACESHEET

WILLIS-KNIGHTON SOUTH		SHREVEPORT, LA	
ADMITTING DIAGNOSIS:		Code	
PRINCIPAL DIAGNOSIS:			
OTHER DIAGNOSES:			
OPERATIONS/OTHER PROCEDURES:		Date	
DISCHARGE STATUS: <input checked="" type="checkbox"/> Routine <input type="checkbox"/> AMA <input type="checkbox"/> SNF/HRF <input type="checkbox"/> HHA <input type="checkbox"/> Expired <input type="checkbox"/> Autopsy <input type="checkbox"/> OTHER		LENGTH OF STAY 2 DAYS	Physician's Signature Date
Account No. K32957088	Admission Date 11/04/16	ER/IP ER	MEDITECH Unit Number K000629604
Room/Bed K.E5518/1	Admission Time 2019		Subscriber Name
Type ADM IN	Location/Service PED		Subscriber DOB
Last INP DATE	Last Discharge Date 05/16/16		Social Security Number 338-89-3614
Name	2247 LEGARDY STREET	Date of Birth 10/01/13	Age 3Y
Street	SHREVEPORT, LA 71107	Race BLACK OR AFRICAN A	Sex F
City/State/Zip	(318)210-3821	Marital Status SINGLE	
Home Phone		Religion NO RELIGION	
County CADDOPARISH			
Name CHILD	Name ALEXANDER, JENNIFER	Street 2247 LEGARDY STREET	City/State/Zip SHREVEPORT, LA 71107
Street	City/State/Zip	Phone (318)210-3821	Relationship: M
City/State/Zip	Occupation CHILD		
Phone			
Name ALEXANDER, JENNIFER	Name ALEXANDER, JENNIFER	Street 2247 LEGARDY STREET	City/State/Zip SHREVEPORT, LA 71107
Street 3011 KITTY LN APT B	Street	City/State/Zip	Phone (318)210-3821
City/State/Zip SHREVEPORT, LA 71107	City/State/Zip	Relationship: M	
Phone (318)210-3821	SSN 435-59-6369		
Name GOD'S GIFT	Accident Date	Arrival Mode C	
Street 2305 MARIAN PL	Prim Care Phy UNKNOWN		
City/State/Zip SHREVEPORT, LA 71109	Attend. Phy CRAIG, ANNA M M.D.		
Phone 000-0000	Other Phys. CRAIG, ANNA M M.D.		
LA HLTHCARE CONN LA ME	1997286459512		MEDICAID
Is this Patient Here for Pre-Op Testing: Do you have an advanced directive that you would like to present to us today? U			
Comment:		Admit Clerk: PATERA, AM	
Notice Given: Y Date Notice Given: 09/23/14		Baby ID Number:	
Reason for Visit: BRONCHIOLITIS-WITH HYPOXIA		Ethnicity: NHILAT	
Preferred Language: ENGLISH		Interpreter ID Number:	
Known Drug Allergies: NKDA		Patient Survey: U	





WILLIS-KNIGHTON SOUTH
K32957086

██████████ L
Craig, Anna M M.D.

DIS IN

K.E5516-1

Report Type: SUMM

DISCHARGE SUMMARY

ADMITTED: 11/04/16
DISCHARGED: 11/06/16

DISCHARGE CONDITION: Good.
DISCHARGE PHYSICIAN: Anna Craig, M.D.

HOSPITAL COURSE: Patient is a three-year-old African-American female, former 27 weeker with BPD who presents with upper respiratory infection, low grade fevers, rhinorrhea and shortness of breath. Patient required L2 on admission up to 2 liters in order to keep oxygen saturation greater than 95% and respiratory rate lower than 40 breaths per minute. Patient tolerated oxygen well. Patient weaned to room air the day prior to discharge. Albuterol was spaced out from q 2 out of q 4 gradually and patient tolerated this well. Patient was continued on Orapred during hospitalization. Orapred was started on day of admission, the first time she went to the ER after she was discharged home. Patient was continued on Rocephin secondary to elevated white blood cell count. This was not thought to be secondary to steroid as she had only started them the day of admission; however, with patient's fever, shortness of breath, hypoxia and elevated neutrophil count, elevated white blood cell count, patient was continued on Rocephin. Patient did excellent while in house. Repeat chest x-ray again showed no infiltrate, therefore Rocephin was discontinued and patient was able to be discharged home to complete a five day course of Orapred and patient also given scripts for albuterol HFA and nebulizer solution. Patient was also sent home on Pulmicort secondary to her BPD.

All instructions were explained to grandmother who was in agreement with the plan and patient was discharged home in stable condition.

CBC on day of admission shows a white blood cell count of 19.4 with platelets unable to perform because they clumped, with a 96% neutrophil count. CBC on day of discharge shows a white blood cell count of 10, platelets 290 and 53% neutrophil count. On chest x-ray performed on day of admission and day of discharge were both within normal limits. No infiltrate seen on either x-ray. BMP performed originally showed elevated BUN on admission, but returned to normal on day of discharge.

DISCHARGE MEDICATIONS: Patient to complete five day course of Orapred at home. Given scripts for Albuterol HFA and nebulizer in addition to



WILLIS-KNIGHTON SOUTH
K32957086

██████████ L
Craig, Anna M M.D.

DIS IN

K.E5516-1

Pulmicort nebulizer solution.


DISCHARGE INSTRUCTIONS: Albuterol q 4 as needed. Pulmicort to be taken b.i.d. Complete Solu-Medrol course. Follow-up with PCP in two to three days following discharge.

FOLLOW-UP APPOINTMENTS: Patient to follow-up with PCP in two to three days following discharge.

FINAL DIAGNOSIS

1. RESPIRATORY DISTRESS.
2. REACTIVE AIRWAY DISEASE.
3. BRONCHOPULMONARY DYSPLASIA.

REC 10 2016 15:10


Craig, Anna M M.D.

Date/Time

PHYS: CRAIAM
DICT DATE: 11/06/16 1231
TRANS DATE: 11/07/16 0919
BY: RAUCHC.HM
REPORT # 2327590

DISCHARGE SUMMARY



WILLIS-KNIGHTON SOUTH
K32957086

██████████ L
Craig, Anna M M.D.

ADM IN

K.E5516-1

Report Type: HP

HISTORY AND PHYSICAL

ADMITTED: 11/04/16

SOURCE OF INFORMATION
Mother.

PRIMARY CARE PHYSICIAN
Scott Walls, MD

CHIEF COMPLAINT
Respiratory distress.

HISTORY OF PRESENT ILLNESS

The patient is a three year-old African-American female with a past medical history of bronchopulmonary dysplasia, born at 27 weeks gestation, who presents with a three day history of runny nose, cough, low grade fevers and respiratory distress. Mother states that she began to feel ill three days prior to admission, with runny nose and congestion. Two days prior to admission she developed wheezing which was responding to albuterol. She also developed a T-Max of 100.3 one day prior to admission. She maintained good p.o. intake however started having increased respiratory distress, tachypnea and retractions, so she was seen in the ER at Willis-Knighton South. There, chest x-ray was noted to be clear. RSV was negative. She was given Solu-Medrol and O2 because of relative hypoxia. White blood cell count was noted to be 19,000 with 15% bands. Patient was therefore started on Rocephin for pneumonia, despite clear x-ray. The patient was started on Orapred, continued on Pulmicort. She was given Robitussin for cough. O2 therapy was started in order to maintain sats greater than 95%.

PAST MEDICAL HISTORY

Born at 27 weeks gestation and receive oxygen for an extended period of time. She has reactive airway disease. No other illnesses.

PAST SURGICAL HISTORY
None.

ALLERGIES
NONE.

IMMUNIZATIONS
Up-to-date.



WILLIS-KNIGHTON SOUTH
K32957086

██████████ L
Craig, Anna M M.D.

ADM IN

K.E5516-1

MEDICATIONS

Albuterol, inhaled as needed.

FAMILY HISTORY

Noncontributory.

SOCIAL HISTORY

The patient lives at home with mother. She is an only child. She attends day care.

REVIEW OF SYSTEMS

A 10-point review of systems reviewed and otherwise negative. See HPI.

PHYSICAL EXAMINATION

VITAL SIGNS: Blood pressure 121/74, temperature 98.4, heart rate 141, respirations 26. Pulse ox 99% on 1 liter.

GENERAL: Well-developed, well-nourished, well-hydrated, in no acute distress, nontoxic.

HEENT: Normocephalic, atraumatic. Conjunctivae clear. Clear rhinorrhea bilaterally. No nasal flaring. Oral mucous membranes are moist.

HEART: Normal S1, S2. Regular rate and rhythm.

LUNGS: Good air movement through all lung fields. Lungs are tight with rhonchi appreciated throughout. No wheezing.

ABDOMEN: Soft, nontender, nondistended. Normoactive bowel sounds.

EXTREMITIES: Cap refill less than 3 seconds. No edema.

MUSCULOSKELETAL: Moves all extremities well. No pain. No contractions. No weakness.

SKIN: No rashes.

NEURO: Normal, nonfocal.

LABORATORY/IMAGING

Chest x-ray is normal. No consolidation. RVS negative. CBC with white count 19.4, Hgb 10.7, HCT 33.7, platelet count unable to be determined as platelets clumped. 82% neutrophils, 15% bands.



WILLIS-KNIGHTON SOUTH
K32957086

██████████ L
Craig, Anna M M.D.

ADM IN

K.E5516-1

ASSESSMENT AND PLAN

Patient is a three year-old former 27 weeker with bronchopulmonary dysplasia who presents with respiratory distress and upper respiratory infection symptoms. RSV is negative at this time, however patient has relative hypoxia and elevated neutrophil count with bandemia. Admit to Dr. Craig. O2 therapy in order to maintain sats greater than 95%, respiratory rate lower than 40 breaths per minute. Rocephin in order to cover for pneumonia despite negative chest x-ray. Repeat chest x-ray in the morning. Continue albuterol q.4 around the clock, per protocol. Tylenol for fever. Regular diet. We will continue IV fluids right now as patient has increased respiratory rate and has poor p.o. intake. We will continue to monitor the patient closely and will follow up comprehensive respiratory PCR panel for viral etiology, however it is possible that patient has a bacterial pneumonia with x-ray that is lagging behind.


Craig, Anna M M.D.

DEC 10 2016 15:00

Date/Time

PHYS: CRAIAM
DICT DATE: 11/05/16 1459
TRANS DATE: 11/05/16 1659
BY: GHOLSB.MR
REPORT #: 2327551

HISTORY AND PHYSICAL

Physician Documentation

Willis Knighton South

Name: Aaliyah [REDACTED]
Age: 3 years Sex: Female DOB: 10/01/2013
Arrival Date: 11/04/2016 Time: 14:58
Bed Post IM3

MRN: K000629604
Account#: K32957086
Private MD: Allen, scott

HPI:

11/04 This 3 years old African Am/Black Female presents to ED via Ambulatory with complaints of **Breathing** jt7
16:25 **Difficulty**.

16:25 The patient has shortness of breath at rest. Onset: The symptoms/episode began/occurred acutely, 3 day(s) jt7
ago. Duration: The symptoms are continuous, and are unchanged since they started. The patient's
shortness of breath is aggravated by nothing, is alleviated by nothing. Associated signs and symptoms:
Pertinent positives: wheezing, Pertinent negatives: chest pain, non-productive cough, productive cough,
diaphoresis, dizziness, fever, hemoptysis, loss of consciousness, nausea, numbness in extremities,
peripheral edema, visual changes, vomiting. Severity of symptoms: At their worst the symptoms were
moderate in the emergency department the symptoms are unchanged. The patient has experienced similar
episodes in the past. The patient has been recently seen by a physician: The patient has been recently seen
at a Willis Knighton Emergency Department, today.

Historical:

- Allergies: No known drug Allergies;
- Home Meds:
 1. Albuterol Nebulizer as needed
- PMHx: Autism
- PSHx: None

Historical:

15:50 Family history: No immediate family members are acutely ill. Immunization history: Childhood immunizations sh1
up to date, Last flu immunization: up to date. Last tetanus immunization: up to date. Social history: The
patient lives with mother The patient speaks appropriately for age, The patient attends SPECIAL ED FOR
SPEECH.

16:25 History obtained from mother. The history from nurses notes was reviewed and confirmed. jt7

ROS:

16:25 ROS as in the HPI, and all other systems were reviewed negative, or noncontributory, except as mentioned jt7
below. Eyes: Negative for injury, pain, redness, and discharge ENT: Negative for injury, pain, and
discharge, Neck: Stiffness, swollen nodes, pain Back: Negative for injury and pain, GU: Negative for injury,
bleeding, discharge, and swelling, MS/Extremity: Negative for injury and deformity, Skin: Negative for rash,
changes Neuro: Negative for headache, weakness, and seizure, Psych: Negative for depression, anxiety,
suicide ideation, homicidal ideation, and hallucinations. Constitutional: Positive for shortness of breath,
Negative for body aches, chills, chronic fevers, crying, fatigue, fever, malaise, obvious distress, acute pain,
poor PO intake, tearful, vomiting. Cardiovascular: Negative for angina, chest pain, edema, orthopnea,
palpitations, paroxysmal nocturnal dyspnea. Respiratory: Positive for shortness of breath, wheezing,
Negative for cough, dyspnea on exertion, hemoptysis, orthopnea, pleurisy, paroxysmal nocturnal dyspnea,
sputum production. Abdomen/GI: Negative for abdominal pain, nausea, vomiting, diarrhea, constipation.

Exam:

16:26 jt7

Head/Face: Normocephalic, atraumatic.

Eyes: Pupils equal round and reactive to light, extra-ocular motions intact. Lids and lashes normal.
Conjunctiva and sclera are non-icteric and not injected. Cornea within normal limits. Periorbital areas with
no swelling, redness, or edema.

ENT: Nares patent. No nasal discharge, no septal abnormalities noted. Tympanic membranes are normal
and external auditory canals are clear. Oropharynx with no redness, swelling, or masses, exudates, or
evidence of obstruction, uvula midline. Mucous membrane moist

Neck: Trachea midline, no thyromegaly or masses palpated, and no cervical lymphadenopathy. Supple, full
range of motion without nuchal rigidity, or vertebral point tenderness. No Meningismus. Lymphatic No
abnormal lymphadenopathy noted by palpation in the neck or axilla

Physician Documentation Con't.

Chest/axilla: Normal chest wall appearance and motion. No deformity. Normal symmetrical motion. No tenderness. No crepitus. No axillary masses or tenderness. No lesions appreciated

Back: Normal inspection with no obvious deformity. No spinal or CVA tenderness. Normal ROM without pain

Skin: Warm and dry with excellent turgor. Capillary refill <2 seconds. No cyanosis, pallor, rash or edema.

MS/ Extremity: Pulses equal, no clubbing, no cyanosis, or edema. Neurovascular intact. Full, normal range of motion without pain

Neuro: Awake and alert. Good muscle tone. Moves all extremities well. Sensory grossly intact

Psych: Behavior, mood, response, and affect are appropriate for age.

Constitutional: The patient appears Blood pressure, pulse, respirations and temperature noted. awake, alert, well developed, well groomed, well hydrated, well nourished, non-diaphoretic, non-toxic, afebrile.

Cardiovascular: Rhythm is sinus tachycardia Pulses: equal and symmetrical bilaterally, in the upper extremities, in the lower extremities, no pulse deficits are appreciated, Heart sounds: normal, normal S1 and S2, no S3 or S4, no murmur, no rub, no gallop, Edema: is not appreciated, JVD: is not appreciated.

Respiratory: the patient does not display signs of respiratory distress. Respirations: labored breathing, is not present, asymmetrical chest movement, is not seen, accessory muscle usage, is absent, grunting, is not present, nasal flaring, is not appreciated, paradoxical chest movement, is absent, prolonged exhalation, is not present, pursed lip breathing, is not present, intercostal retractions, are absent, shallow respirations, are not present, splinting, is not noted, tachypnea, is appreciated Breath sounds: rales, are not appreciated, rhonchi, are not appreciated, crackles, are not appreciated, wheezing, EXPIRATORY WHEEZES NOTED, bronchial sounds, are not appreciated, decreased breath sounds, are not appreciated, stridor, is not appreciated.

Abdomen/GI: Inspection: abdomen appears normal, Bowel sounds: normal, in all quadrants, Palpation: abdomen is soft and non-tender, in all quadrants, mass, is not appreciated, no appreciated hepatomegaly, splenomegaly Hernia: not appreciated.

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Pain	Staff
15:08		182	44 Spontaneous		88%	14.06 kg / 31 lbs 0 oz (R)	6/10	sd4
15:36		186	42	99.6(R)	90% on 1 lpm NC			sh1
16:15					92% on R/A			sh1
17:00		164	40		90% on R/A			sh1
17:30		164	40	98.6(A)	90% on R/A		0/10	sh1
18:00		165	40		89% on R/A			sh1
18:00		164	40		92% on 1 lpm NC			sh1
18:30		165	40		95% on 1 lpm NC			sh1
19:13		166	36		93% on 1 lpm NC			sb6
19:14					96% on 2 lpm NC			sb6
19:44					92% on 2 lpm NC			sb6
20:14					99% on 2 lpm NC			sb6
20:58		177		96.5(A)	100% on 2 lpm NC			sb6

Name: Aaliyah [REDACTED]

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Physician Documentation Con't.

20:58	40	sb6
18:00 pt is sleeping soundly sao2 decreased to 88% on room air will apply oxygen		sh1
20:58 PER SAVANNAH, TECH		sb6

Glasgow Coma Score:

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
15:08	spontaneous(4)	oriented(5)	obeys commands(6)		15	sd4

MDM:

16:07 Patient medically screened. sd5

19:05 Differential Diagnosis viral infection, bacterial infection, URI, bronchitis, pneumonia, UTI, gastroenteritis, meningitis. I personally performed the services described in this documentation as scribed in my presence, and it is both accurate and complete. sd5

Data reviewed: vital signs, nurses notes.

Response to treatment: the patient's symptoms have mildly improved after treatment.

Physician consultation: Dr. Anna Craig MD was called at 19:05, was contacted at 19:05, regarding admission, and will see patient in office.

Order	Status	Time	By	For
Albuterol 1 unit dose Inhalation every 15 minutes x2	Ordered	11/04/16 15:38	raa	raa
	Administered	11/04/16 15:55	sh1	
	Administered	11/04/16 16:00	sh1	
Notes:	Order Method: Electronic			
11/04/16 15:55	Administration: Albuterol 1 unit dose Inhalation over 5 mins			sh1
11/04/16 16:00	Administration: Albuterol 1 unit dose Inhalation			sh1
11/04/16 16:00	Follow Up: Response: No Adverse Reaction; Respiratory status improved; has improved air movement			sh1
11/04/16 16:15	Follow Up: Response: No Adverse Reaction; Respiratory status improved; wheezing has decreased only has audible faint wheezing air movement improved			sh1
Order	Status	Time	By	For
SOLU-MEDrol 2 mg/kg IVP once	Ordered	11/04/16 15:38	raa	raa
	Administered	11/04/16 16:55	sh1	
Notes:	Order Method: Electronic			
11/04/16 16:55	Administration: SOLU-MEDrol 2 mg/kg IVP in left hand over 2 mins			sh1
11/04/16 17:25	Follow Up: Response: No Adverse Reaction			sh1
Order	Status	Time	By	For
Call X-Ray Tech	Ordered	11/04/16 15:39	raa	raa
	Completed	11/04/16 15:40	Blackmon, Connor, ED Tech	
Notes:	Order Method: Electronic			
Order	Status	Time	By	For

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Chest 2 View *routine*	Ordered	11/04/16 15:39	raa	raa
	Reviewed	11/04/16 16:43	Denham, Sean, MD	
Notes: Bed Name: 14	Order Method: Electronic			
ER EXAM ROOM/BED: (OERDERRMBD): 14				
Is the patient able to bear weight? (OERDBEARWT):				
Is the patient at risk for falls? (OERDFALLS):				
MODE OF TRANSPORTATION : (OERDTRANS): STRETCHER				
O2: (OEADO2): No				
REASON FOR EXAM: (OERDEXAM): Breathing Difficulty				
Order	Status	Time	By	For
CBC With Diff	Ordered	11/04/16 16:25	sd5	sd5
	Reviewed	11/04/16 17:52	Denham, Sean, MD	
Notes:	Order Method: Electronic			
COLLECTED BY NURSE? (Y/N) (OELBCBN): No				
Comments: (OEMICCOM):				
Ordering Location: ERSPC100.1				
Quantity 1: 1				
Order	Status	Time	By	For
Chem 8	Ordered	11/04/16 16:25	sd5	sd5
	Reviewed	11/04/16 17:52	Denham, Sean, MD	
Notes:	Order Method: Electronic			
COLLECTED BY NURSE? (Y/N) (OELBCBN): No				
Comments: (OEMICCOM):				
Ordering Location: ERSPC100.1				
Quantity 1: 1				
Order	Status	Time	By	For
COLLECT SWAB	Ordered	11/04/16 16:25	sd5	sd5
	Completed	11/04/16 17:40	Hovingh, Sue, RN	
Notes:	Order Method: Electronic			
Order	Status	Time	By	For
RSV by PCR	Ordered	11/04/16 16:25	sd5	sd5
	Reviewed	11/04/16 18:50	Denham, Sean, MD	
Notes:	Order Method: Electronic			
Ordering Location: ERSPC100.1				
Order	Status	Time	By	For
Hep Lock	Ordered	11/04/16 16:25	sd5	sd5
	Completed	11/04/16 16:57	Mathews, Janet, RN	
Notes:	Order Method: Electronic			

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Order	Status	Time	By	For
WBC Differential, Manual	Ordered	11/04/16 17:03	EDMS	
	Reviewed	11/04/16 17:52	Denham, Sean, MD	
Notes:	Order Method:			
Order	Status	Time	By	For
Rocephin 50 mg/kg IVPB once	Ordered	11/04/16 19:24	sb6	amc
	Administered	11/04/16 20:16	sb6	
Notes:	Order Method: Written			
11/04/16 20:16	Administration: Rocephin 50 mg/kg IVPB in left hand via Primed IVPB Tubing			sb6
11/04/16 21:00	Follow Up: Response: Tolerated well; IV Status: Completed infusion			sb6
Order	Status	Time	By	For
NS - NS 0.9% 1000 mL IV at 50 mL/h Continuous.	Ordered	11/04/16 19:53	sb6	amc
	Administered	11/04/16 20:16	sb6	
Notes:	Order Method: Written			
11/04/16 20:16	Administration: NS - NS 0.9% 1000 mL IV at 50 mL/h in left hand via Primed Infusion Pump Tubing			sb6
11/04/16 21:05	Follow Up: IV Status: Infusion continued			sb6
11/04/16 21:08	Follow Up: IV Status: Infusion continued upon Admission			sb6
Order	Status	Time	By	For
Albuterol 1 unit dose Inhalation once	Ordered	11/04/16 20:24	sb6	amc
	Administered	11/04/16 20:30	sb6	
Notes:	Order Method: Written			
11/04/16 20:30	Administration: Albuterol 1 unit dose Inhalation			sb6
11/04/16 20:41	Follow Up: Response: Tolerated well			sb6
Order	Status	Time	By	For
CBC w/ Diff	Ordered	11/06/16 06:12	EDMS	
	Returned	11/06/16 06:12	Dispatcher MedHost	
Notes:	Order Method:			
Order	Status	Time	By	For
Basic Metab Pnl	Ordered	11/06/16 06:31	EDMS	
	Returned	11/06/16 06:31	Dispatcher MedHost	
Notes:	Order Method:			

Order Signatures:

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Physician Documentation Con't.

Denham, Sean, MD	MD	sd5	Dispatcher MedHost	EDMS
Aycock II, Richard, MD	MD	raa	Craig, Anna, MD	MD amc
Bouillion, Stephenie, RN	RN	sb6		

Disposition:

16:28 This chart was scribed by Titus, Joane, Scribe. in the presence of Sean Denham MD.

jt7

19:05 Electronically signed by: Sean C. Denham, MD. Disposition.

sd5

Disposition:

11/04/16 19:04 Admit ordered for Craig, Anna. Preliminary diagnosis is Bronchiolitis - with hypoxia.

- Bed requested for Specific Bed.
- Condition is Good.
- Problem is new.
- Symptoms are unchanged.

Signatures:

Dispatcher MedHost	EDMS	Aycock II, Richard, MD	MD	raa
Hovingh, Sue, RN	RN	Bouillion, Stephenie, RN	RN	sb6
Denham, Sean, MD	MD	Blackmon, Connor, ED Tech	ED	cb6
Kemp, Christine, ED Tech	ED	Titus, Joane, Scribe	Scribe	jt7
	Tech			

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Nurse's Notes

Name: Aaliyah
Age: 3 years Sex: Female DOB: 10/01/2013
Arrival Date: 11/04/2016 Time: 14:58
Bed Post IM3

Willis Knighton South

MRN: K000629604
Account#: K32957086
Private MD: Allen, scott

11/6

Presentation:

11/04 Method of Arrival: Ambulatory. sd4
15:07
15:08 Preferred language for medical communication is English. Presenting complaint: Mother states: that she is bringing her daughter back because she is not better, still breathing hard. sd4
Person Transporting:
Parent. Transition of care: patient was not received from another setting of care.
15:09 Acuity: 2 - Emergent. sd4

Triage Assessment:

15:08 **General:** Appears well developed, well nourished, Behavior is fussy. Pain: FACES pain scale score is 6 out of 10. sd4

Historical:

Allergies:
15:34 No known drug Allergies; sh1
Home Meds:
15:34 1. Albuterol Nebulizer as needed sh1
PMHx:
15:34 Autism; sh1
PSHx:
15:34 None; sh1

Screening:

15:08 (15:09) **Abuse screen:** sd4
Denies threats or abuse.
(15:09) **Patient fall risk assessment;**
risks identified; None.
(15:09) **Learning Barriers:**
age barrier identified, caregiver ready and willing to learn.
(15:09) **Padi Fall Risk**
None identified.
(15:09) **Exposure risk/Travel Screening:**
None identified. Has not been out of the country.

Historical:

15:50 (15:51) Family history: No immediate family members are acutely ill. (15:51) Immunization history: Childhood immunizations up to date, Last flu immunization: up to date. Last tetanus immunization: up to date. (15:51) Social history: The patient lives with mother The patient speaks appropriately for age, The patient attends SPECIAL ED FOR SPEECH.
16:25 History obtained from mother. The history from nurses notes was reviewed and confirmed. Jt7

Assessment:

15:10 (15:55) Pain: FACES pain scale score is 0 out of 10. (15:55) **General:** Appears well developed, well nourished, well groomed, Behavior is appropriate for age. (15:55) **Neuro:** Level of Consciousness is alert, awake, obeys commands, Oriented to person, place, time, Pupils are PERRLA. (15:55) **EENT:** No deficits noted. (15:55) **Cardiovascular:** Capillary refill < 3 seconds is brisk Heart tones S1 S2 present. (16:01) **Respiratory:** Respiratory effort is even, labored, with nasal flaring, with retractions, shallow, grunting, Respiratory pattern is regular, tachypnea Airway is patent Breath sounds are coarse bilaterally. Breath sounds are diminished bilaterally. Breath sounds with wheezes upon exhalation, HAS WHEEZING THRUOUT LUNG FIELDS Parent/caregiver reports the patient having cough that is dry, hacking, persistent MOTHER REPORTS WE WERE SEEN HERE THIS AM FOR WHEEZING AND COUGHING THEY GAVE RESPIRATORY TREATMENTS AND STEROIDS WE TOOK HER HOME AND SHE JUST CONTINUED TO WORSEN SHE HAS A PERSISTENT COUGH AND HER WHEEZING IS MUCH WORSE AND SHE HAS BEEN RUNNING FEVER WE GAVE TYLENOL 1.5 HOURS AGO. (15:55) **Gastrointestinal:** Abdomen is flat, non-distended Bowel sounds present X 4 quads. (15:55) **Genitourinary:** wears diapers Parent/caregiver reports the patient having normal urinary habits. (15:55) **Dermatologic:** Skin is intact, is healthy with good turgor, Skin is pink, warm & dry. black. (15:55) **Musculoskeletal:** No deficits noted. sh1

Nurse's Notes Con't

Capillary refill < 3 seconds is brisk Range of motion intact in all extremities. Circulation, motion, and sensation intact. (15:55) **Injury Description:** denies injury.

15:56 **Pain:** level that is acceptable is 0 out of 10 on a pain scale.

sh1

19:13 (19:14) **General:** Appears well developed, well nourished, Behavior is appropriate for age. (19:14) **Neuro:** Level of Consciousness is alert, awake, Oriented to person. (19:14) **Respiratory:** Respiratory effort is even, Respiratory pattern is tachypnea Airway is patent Breath sounds with wheezes upon exhalation, in left posterior upper lobe, right posterior upper lobe, left posterior lower lobe, right posterior lower lobe, left posterior base and right posterior base. (19:14) **Dermatologic:** Skin is intact, Skin is dry.

sb6

21:01 **Respiratory:** Respiratory effort is even, Respiratory pattern is tachypnea Breath sounds with wheezes upon exhalation, in left posterior upper lobe, right posterior upper lobe, left posterior lower lobe, right posterior lower lobe, left posterior base and right posterior base.

sb6

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Pain	Staff
15:08 (15:10)		182	44 Spontaneous		88%	14.06 kg / 31 lbs 0 oz (R)	6/10	sd4
15:36 (18:39)		186	42	99.6(R)	90% on 1 lpm NC			sh1
16:15 (17:02)					92% on R/A			sh1
17:00 (17:41)		164	40		90% on R/A			sh1
17:30 (17:42)		164	40	98.6(A)	90% on R/A		0/10	sh1
18:00 (18:38)		165	40		89% on R/A			sh1
18:00 (18:39)		164	40		92% on 1 lpm NC			sh1
18:30 (18:44)		165	40		95% on 1 lpm NC			sh1
19:13 (19:15)		166	36		93% on 1 lpm NC			sb6
19:14 (20:23)					96% on 2 lpm NC			sb6
19:44 (20:23)					92% on 2 lpm NC			sb6
20:14 (20:23)					99% on 2 lpm NC			sb6
20:58 (20:59)		177		96.5(A)	100% on 2 lpm NC			sb6
20:58 (20:59)			40					sb6

18:00 pt is sleeping soundly sao2 decreased to 88% on room air will apply oxygen
20:58 PER SAVANNAH, TECH

sh1

sb6

Vitals:

15:08 (15:10) Acuity: 2 - Emergent.

sd4

15:10 (15:55) Body Mass Index =

sh1

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*Nurse's Notes Con't***Glasgow Coma Score:**

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
15:08 (15:10)	spontaneous(4)	oriented(5)	obeys commands(6)		15	sd4

ED Course:

14:58 Patient arrived in ED. ms2
 14:58 Patient moved to KIOSK. ms2
 15:07 Allen, scott is Private Physician. sd4
 15:10 Triage completed. sd4
 15:10 Patient moved to 14. sd4
 15:10 (15:56) No apparent distress. Resting quietly. (15:56) Awaiting ED physician evaluation. sh1
 15:10 (15:55) Patient/caregiver encouraged to voice any concerns. Side rails up X 1. Placed in gown. Bed in low position. Call light in reach. Instructed to call for assist when getting up, verbalized understanding. Patient has correct armband on for positive identification. Adult with patient. Child being held by parent. (15:55) Pulse ox on. Bedside monitor alarms on and audible. sh1
 15:16 O2 via nasal cannula @ 2L/min. sd4
 15:23 Hovingh, Sue, RN is Primary Nurse. sh1
 15:39 Patient moved to Radiology. aw7
 15:39 Chest 2 View "routine" Sent. aw7
 15:40 (17:06) No apparent distress. Resting quietly. sh1
 16:04 Denham, Sean, MD is Attending Physician. sd5
 16:06 Patient moved to 14. aw7
 16:10 (17:06) No apparent distress. Resting quietly. sh1
 16:40 (17:07) No apparent distress. Resting quietly. breathing much easier past respiratory treatments. sh1
 16:49 Inserted saline lock IV, 22 gauge in left hand. alt1
 16:55 (17:02) Critical Med Co-Sign: Solumedrol 28 mg IVP at 2 mg/kg at 14.06 kg. dosage verified by Janet Mathews, RN. jcm
 17:25 (18:40) No apparent distress. Resting quietly. Appears to be sleeping. sh1
 17:55 (18:42) No apparent distress. Resting quietly. Appears to be sleeping. sh1
 18:25 (18:42) No apparent distress. Resting quietly. Appears to be sleeping. sh1
 18:59 Report given to stephenie m. using the SBAR communication method. sh1
 19:03 Craig, Anna, MD is Admitting Physician. sd5
 19:04 Waiting for Bed Assignment. sd5
 19:05 Primary Nurse role handed off by Hovingh, Sue, RN. sh1
 19:13 Bouillion, Stephenie, RN is Primary Nurse. sb6
 19:13 (19:16) No apparent distress. Resting quietly. IN BED WITH FAMILY MEMBER. (19:16) ER nurse to see patient. sb6
 19:13 (19:16) O2 via nasal cannula @ 2L/min. sb6
 19:13 (19:16) IV maintenance: IV is intact. sb6
 20:10 Waiting for Bed Assignment. ck3
 20:16 (20:17) IV maintenance: IV is patent, is intact. sb6
 20:25 SPOKE WITH PAULY, RT, ABOUT PATIENT STATUS. sb6
 21:07 No procedures done that require assistance. sb6

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Nurse's Notes Con't

21:24 Patient moved to Post IM3.

mm14

Administered Medications:

Time	Drug & Dose	Route	Rate	Duration	Site	Delivery	Staff
15:55 (16:00)	Albuterol 1 unit dose	Inhalation		5 mins			sh1
16:00 (16:13)	Albuterol 1 unit dose	Inhalation					sh1
16:00 (16:16)	Follow up: Response: No Adverse Reaction; Respiratory status improved; has improved air movement						sh1
16:15 (17:05)	Follow up: Response: No Adverse Reaction; Respiratory status improved; wheezing has decreased only has audible faint wheezing air movement improved						sh1
16:55 (17:01)	SOLU-MEDrol 2 mg/kg	IVP		2 mins	left hand		sh1
17:25 (19:02)	Follow up: Response: No Adverse Reaction						sh1
20:16	Rocephin 50 mg/kg	IVPB			left hand	Primed IVPB Tubing	sb6
21:00 (21:01)	Follow up: Response: Tolerated well; IV Status: Completed infusion						sb6
20:16 (20:17)	NS - NS 0.9% 1000 mL	IV	50 mL/h		left hand	Primed Infusion Pump Tubing	sb6
21:05 (21:06)	Follow up: IV Status: Infusion continued						sb6
21:08	Follow up: IV Status: Infusion continued upon Admission						sb6
20:30	Albuterol 1 unit dose	Inhalation					sb6
20:41	Follow up: Response: Tolerated well						sb6

Outcome:

19:04 Admit ordered by MD. sd5

21:07 (21:08) Report called to J. GRIFFITH, RN, using the SBAR communication method. sb6

21:09 (21:14) Moved to Pediatrics Room # 5516, accompanied by nurse, family with patient, via wheelchair, with oxygen, with chart. (21:10) Discharge instructions given to family, Instructed on admit to floor admission process Demonstrated understanding of instructions, Prescriptions given; None. No questions or concerns expressed to me at discharge. (21:10) All belongings were taken to the room upon admit. (21:10) Medication reconciliation form provided. (21:10) Med Effects: Effects of administered medications were addressed. (21:10) Oxygen use: Oxygen used on this visit. sb6

22:32 Electronic medical record closed.

Signatures:

Hovingh, Sue, RN

RN sh1

Mathews, Janet, RN

RN jcm

Name: Aaliyah

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Nurse's Notes Con't

Scriptuser, MEDHOST	ms2	David, Syndee, RN	RN	sd4
Bouillion, Stephenie, RN	RN sb6	Denham, Sean, MD	MD	sd5
Walker, Ansell, RT	RT aw7	Tomlinson, Amy, RN	RN	alt1
McCaa, Mark, ED Tech	ED mm14	Kemp, Christine, ED Tech	ED	ck3
Titus, Joane, Scribe	Tech jt7		Tech	

Corrections:

16:01 45:36 Resp 42bpm; Pulse Ox 90% 2 lpm Nasal Cannula; Temp 99.6F Rectal;	eh4	sh1
16:01 45:40 Respiratory: Respiratory effort is even, labored, with nasal flaring, with retractions, shallow, grunting. Respiratory pattern is regular, tachypnea. Airway is patent. Breath sounds are coarse bilaterally. Breath sounds are diminished bilaterally. Breath sounds with wheezes upon exhalation. HAS WHEEZING THRUOUT LUNG FIELDS Parent/caregiver reports the patient having cough that is dry, hacking, persistent. MOTHER REPORTS WE WERE SEEN HERE THIS AM FOR WHEEZING AND COUGHING THEY GAVE RESPIRATORY TREATMENTS AND STEROIDS WE TOOK HER HOME AND SHE JUST CONTINUED TO WORSENEED SHE HAS A PERSISTENT COUGH AND HER WHEEZING IS MUCH WORSE AND SHE HAS BEEN RUNNING FEVER WE GAVE TYLENOL 1.5 HOURS AGO.	eh4	sh1
16:16 46:14 Response: No Adverse Reaction; Respiratory status improved; has improved air movement	eh4	sh1
17:02 46:10 Critical Med Co Sign: Solumedrol 20 mg IVP at 2 mg/kg at 14.06 kg, dosage verified by Janet Mathews, RN	jcm	jcm
18:38 48:00 Pulse Ox 88% RA; pt is sleeping soundly scc2 decreased to 88% on room air will apply oxygen;	eh4	sh1
18:39 45:36 Pulse 186bpm; Resp 42bpm; Pulse Ox 90% 2 lpm Nasal Cannula; Temp 99.6F Rectal;	eh4	sh1
18:39 48:00 Pulse Ox 92% 1 lpm Nasal Cannula;	eh4	sh1
21:14 24:09 Moved to Pediatrics Room # 5516, accompanied by tech, family with patient, via wheelchair, with oxygen, with chart,	sb6	sb6

Name: Aaliyah [REDACTED]

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Willis Knighton South

Name: Aaliyah

Age: 3 years Sex: Female DOB: 10/01/2013

Arrival Date: 11/04/2016 Arrival Time: 14:58

MRN: K000629604

Account#: K32957086

**EMERGENCY DEPARTMENT
HOME MEDICATION RECONCILIATION****Allergies:** No known drug Allergies

	Home Medication	Route	Dose	Frequency	Last Dose
1	Albuterol	Nebulizer		as needed	

Administered Medications:

Time	Drug & Dose	Route	Rate	Duration	Site	Delivery	Staff
11/04 15:55	Albuterol 1 unit dose	Inhalation		5 mins			sh1
16:00	Albuterol 1 unit dose	Inhalation					sh1
16:00	Follow up: Response: No Adverse Reaction; Respiratory status improved; has improved air movement						sh1
16:15	Follow up: Response: No Adverse Reaction; Respiratory status improved; wheezing has decreased only has audible faint wheezing air movement improved						sh1
16:55	SOLU-MEDrol 2 mg/kg	IVP		2 mins	left hand		sh1
17:25	Follow up: Response: No Adverse Reaction						sh1
20:16	Rocephin 50 mg/kg	IVPB			left hand	Primed IVPB Tubing	sb6
21:00	Follow up: Response: Tolerated well; IV Status: Completed infusion						sb6
20:16	NS - NS 0.9% 1000 mL	IV	50 mL/h		left hand	Primed Infusion Pump Tubing	sb6
21:05	Follow up: IV Status: Infusion continued						sb6
21:08	Follow up: IV Status: Infusion continued upon Admission						sb6
20:30	Albuterol 1 unit dose	Inhalation					sb6
20:41	Follow up: Response: Tolerated well						sb6

Prescriptions:

Prescription	Custom Text
(Nothing entered)	

DISCHARGE INSTRUCTIONS
Change Home Meds as Follows

**ALL ORDERED MEDICATIONS MUST
BE WRITTEN ON HOSPITAL ORDER
SHEET.
THIS DOCUMENT IS NOT
A PHYSICIAN ORDER SHEET**

Lab Results Summary

Name: Aaliyah
 3 years / African Am/Black / Female
 Chief Complaint: Breathing Difficulty

MRN: K000629604
 Arrival: 11/04/2016 14:58
 Departure:

Test	Value	Flag	Range	Units	Status	Updated
CBC With Diff SPEC'M 11/04/16 16:57						
White Blood Cell	19.4	High	4.0-12.0	10	F	
Red Blood Cell	4.43		4.1-5.2	10	F	
Hemoglobin	10.7	Low	11.8-14.7	g/dL	F	
Hematocrit	33.5	Low	35.0-44.0	%	F	
MCV	75.6		74.0-89.0	fL	F	
MCH	24.1	Low	27.1-34.2	pg	F	
MCHC	31.9	Low	33.0-35.6	g/dL	F	
RDW	15.0	High	12.0-14.0	%	F	
Neutrophils	96.8		Not Estab.	%	F	
*See MANUAL DIFF Disregard Automated Differential. *See MANUAL DIFF Disregard Automated Differential.						
Lymphocytes	1.8		Not Estab.	%	F	
Monocytes	1.0	Low	3-10	%	F	
Eosinophils	0.2		0.0-8.0	%	F	
Basophils	0.2		0.0-3.0	%	F	
Neutrophils #	18.7		Not Estab.	10	F	
Lymphocytes #	0.4		Not Estab.	10	F	
Monocytes #	0.2		Not Estab.	10	F	
Eosinophils #	0.0		Not Estab.	10	F	
Basophils #	0.0		Not Estab.	10	F	
Platelet Count	TNP		130-351	10	F	
Unable to perform Platelet Count due to clumping of platelets.						
Chem 8 SPEC'M 11/04/16 16:57						
Glucose	132	High	70-109	mg/dL	F	
Glucose Reference Ranges: Fasting Glucose Level: 70-109 mg/dL Impaired Fasting Glucose: 110-125 mg/dL Defined by the ADA as a category at risk for future diabetes and cardiovascular disease. The American Diabetes Association (ADA) recommends the following criteria for the diagnosis of diabetes: Abnormal Fasting Glucose: ≥ 126 mg/dL Symptoms of diabetes and a random glucose: ≥ 200 mg/dL						
Potassium	5.4	High	3.5-5.1	mmol/L	F	
Sodium	143		136-145	mmol/L	F	
Chloride	113	High	98-107	mmol/L	F	
CO2	18	Low	21-32	mmol/L	F	
BUN	12		7-18	mg/dL	F	
Creatinine	0.40			mg/dL	F	
Calcium	9.8		8.5-10.1	mg/dL	F	
Anion Gap	12.0		5.0-15.0	mmol/L	F	
eGFR *AA	TNP		>60	SeeBelow	F	
eGFR *non	TNP		>60	SeeBelow	F	
RSV by PCR SPEC'M 11/04/16 17:40						
RSV	Negative		Negative		F	
NEGATIVE test results do not preclude RSV infection and should not be used as the sole basis for treatment or other patient management decisions. False negative results may occur if virus is present at levels below the analytical limit of detection or the virus mutates in the target region.						

Lab Results Summary

Comments	See Below					
The results of this assay should be interpreted in conjunction with other laboratory and clinical data.						
WBC Differential, Manual SPEC'M 11/04/16 16:57						
Segmented Neut	82		Not Estab.	%	F	
Banded Neut	15		Not Establish	%	F	
Lymphocytes	3		Not Estab.	%	F	
Hypochromic	1+		NORMAL		F	
Plt Estimate	NORMAL		NORMAL		F	

Chest 2 View *routine*

Final Report

Admitting Diagnosis: BREATHING DIFFICULTY

Reason For Exam: Breathing Difficulty Interpretive Location: KBURGIN

Procedure Date: 11/04/2016 Accession Number: 3395212

Procedure: SXR - XR, chest 2 view CPT Code: 71020

IMPRESSION: No Acute Cardiopulmonary Disease.

RESULT: XR, chest 2 view

Clinical Information: Breathing Difficulty

Comparison: 11/4/2016

Findings: Cardiomedial silhouette normal. Trachea midline. Pulmonary vasculature normal. No perihilar opacity or confluent consolidation present. No pneumothorax or pleural effusion seen. Aortic arch and stomach bubble are left-sided. Osseous structures normal.

Electronically Signed by: KOREY PATRICK BURGIN M.D. on Nov 4 2016 4:14P
3395212

RUN DATE: 11/06/16 Willis Knighton South *ADMISSIONS* PAGE 1
 RUN TIME: 1042 Discharge Orders/Discharge Medication Reconciliation
 RUN USER: VANNV.NS

WKHS PNEUMOCOCCAL Vaccine Protocol
 PREVNAR 13 (Pneumococcal 13 Valent Vaccine)
 Administer Year Round

Contraindications (Do NOT administer)
 (Check all that apply)

- ☒ Patient does not meet vaccine indications below
- ☐ Patient has received Pneumovax (Pneumococcal 23 Valent) vaccine within the last year
- ☐ Patient has received Prevnar-13 (Pneumococcal) 13 Valent Vaccine
- ☐ Patient refused vaccine
- ☐ Known sensitivity to previous dose of pneumococcal vaccine
- ☐ Known sensitivity to Diphtheria Toxoid containing vaccines

Indications (Check all that apply)

- ☐ 65 years of age or older AND none of the contraindications above
- ☐ 65 years of age or older, pneumococcal vaccination status unknown AND none of the contraindications above

If NO Contraindications
 Administer Prevnar-13 (Pneumococcal 13 Valent Vaccine)

☐ 0.5 mL IM

Lot Number: _____ Manufacturer: _____

Date on vaccine information sheet: _____ Vaccine Information Sheet (VIS) given to patient: YES NO

Patient vaccine consent: _____
 Patient Signature

*Document administration of vaccine on patient's MAR

Kayla Bragg RN
 Assessment completed by:

11/6/16 1103
 Date / Time

Kayla Bragg RN
 Printed Name

Clarification (by Pharmacy) of Prevnar-13 (Pneumococcal 13 Valent Vaccine order):

- ☐ The patient has received Pneumovax (Pneumococcal 23 Valent) in the last year. Do NOT administer
- ☐ The patient has previously received Prevnar-13 (Pneumococcal 13 Valent). Do NOT administer

Assessment clarification completed by: _____ Date / Time _____ Printed Name _____

This is a protocol approved by Medical Staff 9/2006 and revised 9/2007, 12/2010, 4/2012, 09/2013, 08/2015; therefore does not require a physician signature. This is in accordance with the Law Governing the Practice of Nursing and Louisiana State Board of Medical Examiners position statement. (LSBN, Examiner, Winter 2003)

THIS DOCUMENT IS A PERMANENT PART OF THE MEDICAL RECORD



Name: _____ L
 Acct#: K32957086
 Room/Bed: K.E5516-1
 DOB: 10/01/13 Age: 3Y 01M Sex: F Weight: 31

RUN DATE: 11/06/16
 RUN TIME: 1042
 RUN USER: VANNV.NS

Willis Knighton South *ADMISSIONS*
 Discharge Orders/Discharge Medication Reconciliation

PAGE 2

WKHS Adult Influenza Vaccine Protocol
 INFLUENZA Vaccine [Quadrivalent Inactivated (killed)]
 Administer September - March
 Contraindications (Do NOT administer)
 (Check all that apply)

- ☒ Patient under age 18 years of age
☐ Vaccine not required (April - August)
☐ Patient previously immunized this flu season.
☐ Patient refused vaccine
☐ History of serious reaction to vaccine
☐ History of allergy to eggs
☐ History of Guillain-Barre Syndrome

Indications
 (Check all that apply)

- ☐ 18 years of age or older AND none of the contraindications above

If NO Contraindications
 Administer Influenza (Quadrivalent) Vaccine

- ☐ 0.5 mL IM

Influenza vaccine given

Lot number: _____ Manufacturer: _____

Date on vaccine information sheet: _____ Vaccine Information Sheet (VIS) given to patient: YES NO

Patient vaccine consent: _____
 Patient's Signature

*Document administration of vaccine on patient's MAR

Kayla Brayton RN
 Assessment completed by:

11/6/16 1103
 Date / Time

Kayla Brayton
 Printed Name

This is a protocol approved by Medical Staff 9/2006 and revised 9/2007, 12/2010, 4/2012, 09/2013, 08/2015; therefore does not require a physician signature. This is in accordance with the Law Governing the Practice of Nursing and Louisiana State Board of Medical Examiners position statement. (LSBN, Examiner, Winter 2003)

THIS DOCUMENT IS A PERMANENT PART OF THE MEDICAL RECORD



Name: _____ L
 Acct#: K32957086
 Room/Bed: K.E5516-1
 DOB: 10/01/13 Age: 3Y 01M Sex: F Weight: 31

RUN DATE: 11/06/16
 RUN TIME: 1042
 RUN USER: VANNV.NS

Willis Knighton South *ADMISSIONS*
 Discharge Orders/Discharge Medication Reconciliation

PAGE 3

Date of Discharge: 11/6/16

Discharge patient to: _____

☐ Home Health☐ Physical TherapyDiagnosis: RADAllergies: NKDA
NKDAFollow-up: PCP in 3-4 daysDiet: Regular

Vaccine Protocol:

☒ Follow Flu/Pneumonia Vaccine Protocol

Activity:

☐ Resume normal activity☐ No driving☐ Other: _____☐ Per physician instruction sheet☐ No climbing stairs☐ No lifting

Hygiene Restrictions:

☐ No restrictions☐ Shower only☐ Tub bath only☐ Sponge bath only☐ Other: _____

IV Therapy:

☐ discharge with saline lock in place☐ discharge with PICC line in place☐ discharge with central line in place☐ discharge with port access needle in place

Drainage devices:

☐ discharge with urinary catheter in place☐ discharge with _____ drain in place☐ discharge with (other) _____ in place

OR

☐ Complete NIHSS on discharge (WKP only)

2

☐ See physician discharge sheet (attached)

Name: _____ L

Acct#: K32957086

Room/Bed: K.E5516-1

DOB: 10/01/13 Age: 3Y 01M Sex: F Weight: 31

RUN DATE: 11/06/16
RUN TIME: 1042
RUN USER: VANNV.NS

Willis Knighton South *ADMISSIONS*
Discharge Orders/Discharge Medication Reconciliation

PAGE 4

DISCHARGE MEDICATION RECONCILIATION

Continue at home?
Please circle

HOSPITAL MEDICATIONS

Yes ☒ No

ORAPRED U/D (PREDNISOLONE)

14MG (4.67MLS)

(REFRIGERATE!)

PO

.DAILY

Change:

mother has to meds @ home - finish course

Yes ☒ No

PULMICORT RESPUL (BUDESONIDE)

0.25 MG

INH

.BID

(USE VIA INHALATION NEBULIZATION ONLY!)

Change:

given Rx

Continue at home?
Please circle

IV MEDICATIONS

Yes ☒ No

CEFTRIAXONE 500 MG VIAL (700 MG)
(ROCEPHIN)

RATE: 50 MLS/HR

FREQ: Q24H

IN: DSW 50 ML BAG (50 ML)
(DSW)

Change:

Continue at home?
Please circle

PRN MEDICATIONS

Yes ☒ No

PEDIA PROFEN (IBUPROFEN PED. SUSP)
50MG (2.5MLS)

PO

PRN .Q6H

PRN TEMP > 102.5 DEGREES F, NOT RELIEVED BY
TYLENOL

(SHAKE WELL!) (SAME AS ADVIL/MOTRIN)

Change:

Yes ☒ No

PROVENTIL U/D (ALBUTEROL SOLUTION 0.083%)
AS DIRECTED

INH

PRN .Q2H WHEEZING

(USE VIA INHALATION NEBULIZATION ONLY!)

Change:

given Rx

Yes ☒ No

ROBITUSSIN PED L-A COUGH (DEXTROMETHORPHAN PED)
5 MLS

PO

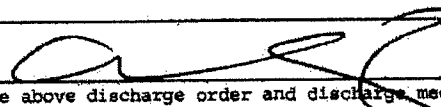
PRN .Q6H COUGH

(ROBITUSSIN PEDIATRIC L-A COUGH)

Change:



Name: HENDERSON, YAH L
Acct#: K32957086
Room/Bed: K.E5516-1
DOB: 10/01/13 Age: 3Y 01M Sex: F Weight: 31

RUN DATE: 11/06/16		Willis Knighton South *ADMISSIONS*		PAGE 5	
RUN TIME: 1042		Discharge Orders/Discharge Medication Reconciliation			
RUN USER: VANNV.NS					
Yes	No	RT PROTOCOL (RT PROTOCOL)	INH	PRN .UD	
		PROTOCOL AS DIRECTED	FOR ADULTS: Atrovent and/or Xopenex Inh Soln via nebulization per respiratory therapy.		
			FOR PEDIATRICS: Proventil Inhalation Soln via nebulization per respiratory therapy.		
Change:					
Yes	No	TYLENOL (ACETAMINOPHEN)	PO	PRN .Q4H	
		80MG (2.5MLS)	PRN TEMP >/- 101 DEGREES F, (DO NOT EXCEED 4,000 MG/24HRS!)		
Change:					
ADDITIONAL MEDICATIONS (NEW MEDICATIONS)					
Physician Signature: 			Date: 11/6/16 Time: 1050		
Signature certifies the above discharge order and discharge medications					
Clarifications, if necessary					
Physician Signature: _____			Date: _____ Time: _____		
(Signature only needed if clarifications are noted)					

Noted: Kayla Bragg RN 11/6/16 1117



Name: [REDACTED] YAH L
Acct#: K32957086
Room/Bed: K: B5516-1
DOB: 10/01/13 Age: 3Y 01M Sex: F Weight: 31

RUN DATE: 11/06/16
RUN TIME: 1042
RUN USER: VANNV.NS

Willis Knighton South *ADMISSIONS*
Discharge Orders/Discharge Medication Reconciliation

PAGE 6

Home Medications NOT An Order

For Information/Comparison Only

ALBUTEROL

1/2 UD

HHN

Q 4 HRS PRN

ANTIFUNGAL CREAM

TOP

Q DAY

NOT AN ORDER



Name: HENDERSON, [REDACTED] L

Acct#: K32957086

Room/Bed: K.E5516-1

DOB: 10/01/13 Age: 3Y 01M Sex: F Weight: 31



Date Ordered	Time Ordered	Orders
11-5-16	1600	CACAB ✓
		BMP ✓ <i>in AM</i>
		CXR ✓
		<i>In AM</i>
		<i>In TOV Dr. Craig / Becky George, R.N.</i>
		<i>✓ 11-5-16 1600 Becky George, R.N.</i>
11/6/16	1300	Chart Review. <i>Glenda R.</i>

Prohibited Abbreviation:

IU
MgSO4
MS
MS04
QD or qd

Please Use:

international unit
magnesium sulfate
morphine sulfate
morphine sulfate
daily

Prohibited Abbreviation

q.o.d. or QOD
U or u
Trailing zero (x.0 mg)
Lack of leading zero (.x mg)

Please Use:

every other day
unit
Never write a decimal point (X mg)
Always use a zero before a decimal point (O.x mg)

Committee Approved Blank Order Form – Must be Hand Written

PO0005



KALIYAH L

10/01/2013 003Y 01M F
Anna Craig
K32957086 11/04/2016 K.E55161

Printed: 11/04/2016